

STAFF REPORT FOR A DETERMINATION OF NEED

Applicant Name	CareGroup, Inc.
Applicant Address	109 Brookline Avenue Boston, MA 02215
Date Received	July 28, 2018
Type of DoN Application	Hospital/Clinic Substantial Capital Expenditure
Total Value of the project	\$593,560,750.00
Ten Taxpayer Group (TTG)	None registered
Public Hearing	None requested
Public Comment	None received
Community Health Initiative (CHI)	Total CHI commitment: \$29,678,037.50 - Tier 3
Staff Recommendation	Approval
Public Health Council Meeting	January 9, 2019

Project Summary and Regulatory Review

CareGroup Inc. (Applicant) submitted a Determination of Need (DoN) application for a Substantial Capital Expenditure at Beth Israel Deaconess Medical Center (BIDMC). The application is for construction of a 10-story structure of 375,000 gross square feet (GSF) to be known, in this Application as the New Inpatient Building (NIB or Project) on the BIDMC West Campus located at 111 Francis Street Boston, MA.

Applications for a Substantial Capital Expenditure are reviewed under the DoN regulation 105 CMR 100.000. Under the regulation, the Department must determine that need exists for a Proposed Project, on the basis of material in the record, where the Applicant makes a clear and convincing demonstration that the Proposed Project meets each Determination of Need factor set forth within 105 CMR 100.210. This staff report addresses each of the six factors set forth in the regulation.

Background

CareGroup

CareGroup, Inc. (CareGroup) is a Massachusetts non-profit corporation that oversees a regional health care delivery system comprised of teaching and community hospitals, physician groups and other caregivers.¹ CareGroup is the parent corporation and sole corporate member of Beth Israel Deaconess Medical Center (BIDMC) and its owned community hospitals Beth Israel Deaconess Hospital-Milton (BID-Milton), Beth Israel Deaconess Hospital-Needham (BID-Needham), and Beth Israel Deaconess Hospital-Plymouth (BID-Plymouth), Mount Auburn Hospital (MAH), and New England Baptist Hospital (NEBH). CareGroup is the corporate entity under which BIDMC, MAH, and NEBH jointly borrow funds and purchase common services, such as insurance coverage and investment services, but do not jointly contract with payers or share centralized operations.^{2,3} This Proposed Project is filed in the context of a separate transaction through which CareGroup will become part of a new health system, Beth Israel Lahey Health (BILH) and, as a corporate entity, will cease to exist independently.⁴

Beth Israel Deaconess Medical Center (BIDMC)

Beth Israel Deaconess Medical Center (BIDMC) is a 673-bed academic medical center (AMC) and teaching-affiliate of Harvard Medical School.⁵ BIDMC offers a full-range of adult clinical services to patients in Eastern Massachusetts, including cardiovascular care, cancer care, care for digestive diseases, OB/GYN, neonatology, neurosciences, orthopedics, psychiatry/behavioral health and transplantation and emergency services including a Level 1 Trauma Center accessible by a rooftop helipad. BIDMC's two hospital campuses – the East Campus and the West Campus, are located a block from each other in the Longwood Medical and Academic Area (LMA).⁶

Clinically Integrated Network

The BID-Network includes BIDMC-owned community hospitals (BID-Milton, BID-Needham, and BID-Plymouth), four hospitals affiliated through Beth Israel Deaconess Care Organization

¹ CareGroup, Inc. (n.d.). Retrieved August, 2018, from <http://www.caregroup.org/CGOverview.asp>

² DoN Application CG-18051612-HE, Application Narrative, footnote 1.

³ *The Proposed Merger of Lahey Health System; CareGroup and its Component Parts, Beth Israel Deaconess Medical Center, New England Baptist Hospital, and Mount Auburn Hospital; Seacoast Regional Health Systems; and Each of their Corporate Subsidiaries into Beth Israel Lahey Health; AND The Acquisition of the Beth Israel Deaconess Care Organization by Beth Israel Lahey Health; AND The Contracting Affiliation Between Beth Israel Lahey Health and Mount Auburn Cambridge Independent Practice Association (HPC-CMIR-2017-2)* (Rep.). (2018, September 27). Retrieved October 1, 2018, from HPC website: https://www.mass.gov/files/documents/2018/09/27/Final_CMIR_Report_-_Beth_Israel_Lahey_Health.pdf (hereinafter, Final CMIR)

⁴ Final CMIR

⁵ 673 beds: 493 Medical/Surgical, 69 Intensive Care Unit, 8 Coronary Care Unit, 62 Obstetrics Services, 16 Neonatal Intensive Care Unit, and 25 Psychiatric Service.

⁶ The BIDMC East Campus has 268 beds (178 Medical/Surgical, 12 Intensive Care Unit, 62 Obstetrics Services, and 16 Neonatal Intensive Care Unit). The BIDMC West Campus has 405 beds (315 Medical/Surgical, 57 Intensive Care Unit, 8 Coronary Care Unit, and 25 Psychiatric Service).

(BIDCO) (Anna Jaques Hospital, Cambridge Health Alliance, and Lawrence General Hospital, and New England Baptist Hospital); Community Care Alliance (CCA) Health Center affiliates (Bowdoin Street Health Center (BIDMC satellite), The Dimock Center, Fenway Health, Outer Cape Health Services, Charles River Community Health, and South Cove Community Health Center); health care providers (Atrius Health, Joslin Diabetes Center, and Hebrew SeniorLife), and numerous physician groups.^{7,8} BIDMC reports that it is the preferred referral partner for tertiary and quaternary services for BID-owned community hospitals and BIDCO contracting affiliate hospitals.⁹

Beth Israel Lahey Health

On October 10, 2018 the Public Health Council (PHC) voted to amend the approved Notice of Determination of Need for DoN Application NEWCO-17082413-TO for an affiliation/transfer of ownership through which a new corporation, to be known as Beth Israel Lahey Health (BILH), would serve as the sole corporate member of 13 clinically and geographically complementary hospitals. CareGroup, along with Lahey Health System, Inc., and Seacoast Regional Health Systems, were parties to the transaction. It is anticipated that the affiliation will be completed in the first quarter of 2019.

The Project

The Proposed Project is located at Beth Israel Deaconess Medical Center (BIDMC) and involves the construction of a 10-story, New Inpatient Building (NIB or Project) on BIDMC's West Campus at 111 Francis Street bounded by Brookline Avenue, Francis Street, Pilgrim Road, and BIDMC's Rosenberg Building. The Applicant states that the NIB will include: up to 158 single-bedded inpatient rooms (up to 128 medical/surgical (M/S) beds and up to 30 additional intensive care unit (ICU) beds); a perioperative floor with eight operating rooms, four procedure rooms, and associated patient care and support areas; ancillary clinical services; conference and education space; a rooftop green space and healing garden; a medical helicopter landing pad (helipad) relocated from the immediately adjacent Rosenberg Building; and connections to the Rosenberg and Farr Buildings.^{10,11}

⁷ The Beth Israel Deaconess Care Organization (BIDCO) is BIDMC's clinically integrated network affiliate. BIDCO is a value-based physician and hospital network and a Massachusetts Health Policy Commission (HPC) certified Accountable Care Organization (ACO). In its CMIR (HPC-CMIR-2017-2), HPC states that BIDCO contracts with payers on behalf of its members and provides its members with information sharing and clinical integration structures to support risk contract success.

⁸ Community Care Alliance is a network of six health centers affiliated with BIDMC. CCA health centers are committed to serving vulnerable and underserved populations. Five of the health centers are Federally Qualified Health Centers (FQHCs). See BIDMC 2016 CHNA <https://www.bidmc.org/-/media/files/beth-israel-org/about-bidmc/helping-our-community/community-initiatives/community-benefits/bidmc-2016-chna-community-health-needs-assessment.ashx?la=en&hash=C5E6B418E4BD56CEE889C55D82CC3538B8F96D33>

⁹ Final CMIR

¹⁰ The Proposed Project does not include the addition of new parking spaces and the Applicant states that all parking for the facility will be accommodated by the existing parking supply within the BIDMC Campus.

¹¹ The Applicant states that BIDMC will, upon the opening of the NIB, close up to 89 West Campus medical/surgical beds, resulting in a net of 69 new beds (39 of the medical/surgical and 30 of the ICU beds) added to the BIDMC

The Applicant states that BIDMC is faced with an aging facility with capacity constraints and a growing patient panel with an increasing need for complex care and treatment. The Applicant asserts there is insufficient existing space to undertake the improvements needed to address space constraints and meet patient care needs; and that the Proposed Project will improve access to and the delivery of high-quality care at BIDMC.

According to the Applicant, it has been more than 20 years since the last time a new building was constructed on the BIDMC campus. During that time, BIDMC gradually relocated services and renovated existing facilities, in order to integrate and coordinate care between its two campuses and to upgrade its aging facilities. The Applicant states BIDMC's existing buildings are constrained by design and size, and asserts that it is no longer cost-effective to further renovate them. The Applicant maintains that a new structure is needed to support the delivery of high-quality complex treatment that addresses the variety of patient panel care needs at BIDMC.

The Applicant is proposing the construction of the NIB, a new inpatient clinical building which will address inpatient capacity and space constraints. The NIB will, according to the Applicant, meet growing patient volume and acuity, and address the diverse and complex care needs of the BIDMC patient panel. The Applicant asserts that the NIB will operate more efficiently and effectively resulting in improved health outcomes, quality of life, and the patient care experience. In so doing, the NIB will allow BIDMC to continue to serve as a high-value tertiary and quaternary hub for all patients in its network and to offer its patient panel increased access to its high quality lower-cost network of providers.

Upon completion of the BILH merger, the Applicant states that BIDMC will serve as the academic medical center (AMC) for the entire BILH system. The Applicant asserts that BILH member hospitals will operate in distinct and complementary geographies and that after the merger each will continue to provide healthcare services to its unique populations. While the NIB will serve the needs of BIDMC's existing patient panel and these needs will remain largely consistent after the formation of BILH, the Applicant acknowledges that as the AMC for the entire BILH system, BIDMC can expect referrals from the other entities that make up the BILH system. As a result, BIDMC may experience a higher acuity case mix following the merger. However, the overall numbers of patients cared for at BIDMC are not anticipated to rise as the lower acuity patients will be treated at appropriate facilities within the BILH network.

Analysis

This analysis and recommendation reflect the purpose and objective of DoN, which is "to encourage competition and the development of innovative health delivery methods and population health strategies within the health care delivery system to ensure that resources will be made reasonably and equitably available to every person within the Commonwealth at the

West Campus bed count at the time that the NIB opens. BIDMC plans to re-open 20 beds within the existing West Campus facilities 24 months after the NIB opens (2024). Overall, BIDMC anticipates up to 89 new medical/surgical and ICU beds on the West Campus two years after the opening of the NIB.

lowest reasonable aggregate cost advancing the Commonwealth's goals for cost containment, improved public health outcomes, and delivery system transformation" 105 CMR 100.001.

All DoN factors are applicable in reviewing a capital expenditure Proposed Project. This Staff Report addresses each of these factors in turn.

Factors 1 and 2

Factor 1 of the DoN regulation requires that the Applicant address patient panel need, and demonstrate that the project will add measurable public health value in terms of improved health outcomes and quality of life for the existing patient panel, while providing reasonable assurances of health equity. Under factor 1, the Applicant must provide evidence of consultation with government agencies that have licensure, certification or other regulatory oversight which, in this case, has been done and so will not be addressed further in this staff report. Under factor 2 of the regulation, the Applicant must demonstrate that the project will meaningfully contribute to the Commonwealth's goals for cost containment, improved public health outcomes, and delivery system transformation. This analysis will approach the requirements of factors 1 and 2 by describing each element of the Proposed Project and how each element complies with those parts of the regulation.

Patient Panel and Need

The DoN Regulation defines patient panel as that of the Applicant, which in this case is CareGroup. CareGroup asserts that its member hospitals operate for the most part, on an autonomous basis. CareGroup provided information on the BIDMC patient panel as well, affirming the Proposed Project, located entirely on the BIDMC West Campus, is designed to address the needs of the BIDMC patient panel, which includes residents from surrounding communities and referrals of high acuity inpatients which historically has been from within the BID-Network. The Department staff agrees that the BIDMC patient panel provides the appropriate basis for analysis of the Proposed Project as required in factor 1.

CareGroup Patient Panel

The patient panel consisted of 1,956,670 patients from FY15-FY17. The patient panel increased by 1.7% between FY15 (640,872) and FY17 (651,978). The gender mix of the patient panel is 59.1% female, 40.8% male, and 0.1% other.¹² Just less than 6% of the patient panel is between the ages of 0 and 17 years, 67.3% are 18 to 64 years, and 26.9% are age 65 and over. The racial mix of the patient panel, based upon self-reported information, is White (66.6%), Asian (7.8%), Black or African-American (7.5%), Hispanic/Latino (2.1%), American Indian or Alaska Native

¹² Patients for whom a gender is not specified or whose gender varies across visits over the time period are included in "Other." DoN Application CG-18051612-HE, Application Narrative at page 111.

(0.1%), Native Hawaiian or Other Pacific Islander (0.1%), and Other (15.8%).¹³ The payer-mix is Commercial (51.0%), Medicare (23.6%), Medicaid (14.3%), Multiple Payers (4.9%), and Other (4.7%).^{14,15} The Applicant states that the patient panel originates from an expansive geographic area with the highest concentration coming from the Greater Boston Area.

BIDMC Patient Panel

The BIDMC patient panel consisted of 104,619 patients from FY15-FY17 at the BIDMC East and West Campuses.¹⁶ The gender mix of the patient panel is 55.4% female and 44.6% male.¹⁷ Based on self-reporting, the racial mix is White (62.3%), Black/African-American (12.7%), Asian (7.0%), Unknown/Not Specified (11.8%) and Other (6.2%).^{18,19} Thirteen percent of the patient panel are newborns, 1% is between the ages of 10-19, 54% is between the ages of 20-64, and 32% are age 65 and older.²⁰ The payer mix of the BIDMC patient panel is Medicare (29.0%), Medicaid (15.5%), Health Safety Net (0.9%), Neighborhood Health Plan (5.7%), Commercial (44.9%), and Other (4%).^{21,22,23}

¹³ Racial information is self-reported. Only data provided by BIDMC includes a separate Hispanic/Latino category. Patients for whom race is not specified or whose race varies across visits over the time period are included in "Other". DoN Application CG-18051612-HE, Application Narrative at page 111.

¹⁴ The remainder is unknown.

¹⁵ Patients whose primary payer is missing in the data are included in "Unknown." Patients whose primary payors within a given fiscal year fall into more than one payer category are included in "Multiple Payers." "Other" includes the following payer categories: self-pay, worker's compensation, other government payment, free care, health safety net, auto insurance Commonwealth Care/ConnectorCare plans, and dental plans. DoN Application CG-18051612-HE, Application Narrative at page 112.

¹⁶ Patient panel data represented FY15, FY16, and FY17. BIDMC operates on a FY basis from October 1 through September 30. DoN Application CG-18051612-HE, Application Narrative, fn19.

¹⁷ For DoN patient panel data collection purposes, BIDMC tracks patient gender using the categories male and female. Patients are provided opportunities to express other gender preferences during their treatment and care. DoN Application CG-18051612-HE, Responses to DPH Questions, at page 3.

¹⁸ The Applicant states that 8.0% of the patient panel identified themselves as Hispanic/Latino. Patients who are Hispanic/Latino may be of any race. BIDMC collects data on whether patients consider themselves Hispanic/Latino or non-Hispanic/Latino, but does not collect data on ethnicity of patients. DoN Application CG-18051612-HE, Application Narrative, fn33.

¹⁹ The Applicant states that patients identified as "Other" or "Unknown/Not Specified" either because they preferred not to report their race, or they identify themselves with a race that does not align with one of the provided options. Other includes the following races: American Indian/Alaska, Caribbean Island, Middle Eastern, multiracial ethnicity, Native Hawaiian or Pacific Island, Portuguese, South American, or Other. DoN Application CG-18051612-HE, Application Narrative, at page 17.

²⁰ The Applicant states that BIDMC does not admit patients under the age of 10, other than newborns. DoN Application CG-18051612-HE, Application Narrative, fn 27.

²¹ Other Category includes Other Healthcare Facility (2.6%), Self-Pay (0.9%), Workers Comp Insurance (0.3%), and Auto Liability Insurance (0.2%)

²² The Applicant states that the payer mix reflects the percentage of patient panel encounters for all service lines by payer group for the period FY15 through FY17. The Applicant notes in FY17, 57% of patient panel encounters for Internal Medicine, BIDMC's largest service line, were paid by Medicare and Medicaid. DoN Application CG-18051612-HE, Application Narrative, at page 14.

²³ Medicaid includes all Medicaid Managed care other than Neighborhood Health Plan. BIDMC's database does not distinguish between the Medicaid and commercial components of Neighborhood Health Plan. The Applicant notes

BILH Transaction

As noted above, CareGroup is a party to a proposed affiliation through which a new corporation, to be known as Beth Israel Lahey Health (BILH), will serve as the sole corporate member of 13 clinically and geographically complementary hospitals. In the context of the proposed transaction, each of the proposed Members of BILH who are not part of CareGroup has certified that they were apprised of the NIB project and that it is consistent with their expectations as parties to the BILH transaction and, further that BILH will, subject to approval by the Department, in accordance with the Regulation, become the Holder of and obligated to all Conditions in any NIB DoN. In addition, the Applicant discussed and staff has considered the requirements of factor 1, specifically patient panel need, knowing that upon closing of the proposed BILH transaction, the need for services generated by the new system may have an impact upon the analysis. As noted, the Applicant states that the BILH member hospitals will operate in distinct and complementary geographies and that after the merger each will continue to provide healthcare services to its unique populations. CareGroup acknowledges that as the AMC for the entire BILH system, BIDMC can expect referrals from the other entities that make up the BILH system and that as a result, BIDMC may experience a higher acuity case mix following the merger. However, the overall numbers of patients cared for at BIDMC are not anticipated to rise as the lower acuity patients will be treated at appropriate facilities within the BILH network.

Need - Capacity Constraints and Improved Care Delivery

The Applicant asserts that BIDMC is experiencing inpatient capacity constraints that are adversely impacting its ability to provide optimal care to its own patient panel. The Applicant states that only 37% of BIDMC's medical/surgical beds are in single-bedded rooms and asserts that increasing inpatient volume, high occupancy rates, and the need to block beds in double-bedded rooms are exacerbating capacity constraints.²⁴ The Applicant reported that in FY17, on average 9.7 beds (range of 4 to 23 beds) were blocked per day because a double-bedded room needed to be used for a single patient. Such room-blocking results from gender incompatibility, infection risk, and other patient-care related needs and, the Applicant asserts, further reduces BIDMC's inpatient capacity.

The Applicant states that from FY15 to FY17, BIDMC experienced a 4.3% increase in inpatient admissions and a 7.5% increase in average daily census for all services, and that BIDMC needs

that over the 12-month period ending 07/30/2015, 74.9% of inpatient cases at BIDMC covered by Neighborhood Health Plan were Medicaid patients. DoN Application CG-18051612-HE, Application Narrative, Table 4.

²⁴ The Applicant states that a blocked bed in double-bedded rooms is a licensed bed that cannot be used for patient care for some period of time. DoN Application CG-18051612-HE, Application Narrative, at page 32.

to increase bed capacity to manage the increasing demand. The Applicant reported that BIDMC's average M/S and ICU bed occupancy rates for FY17 were 92% and 84%, respectively, and asserts that BIDMC's high occupancy rates reduce inpatient bed availability. The Applicant points to standard optimal occupancy rates for medical/surgical units with a mix of single-bedded and double-bedded rooms (85%), and for intensive care unit beds (ICU) beds (80%), as evidence of BIDMC's need for additional inpatient capacity to reduce its high occupancy rates.²⁵

CareGroup asserts that the needs of a variety of patients, including populations with a need for increased access to healthcare services, will be better served by offering a single-bedded room environment. CareGroup states that the room design in terms of the size and layout, will also more effectively serve patients who need to have health care information provided in a language other than English²⁶; patients whose size indicates the need for a specially designed room²⁷; patients with a behavioral health co-morbidity for whom a private room is indicated²⁸; and patients for whom gender identity mitigates in favor of a private room.²⁹

In addition to providing for additional single-bedded capacity, the Applicant asserts that additional inpatient capacity is needed to provide care to a patient panel that is growing increasingly complex. According to the Applicant, BIDMC serves an aging and high acuity patient population, with multiple chronic conditions and/or co-morbid behavioral health diagnoses. The Applicant states that BIDMC is the referral center for the sickest patients requiring complex care within the BID-Network of providers. This, the Applicant asserts, results in an increasing number of high acuity patients at BIDMC. CareGroup reported that BIDMC's overall case mix index (CMI) increased by 5.5% from FY15 (1.63) to FY 2017 (1.72); and notes that this is the same period in which BIDMC also cared for a higher volume of inpatients. CareGroup points out that BIDMC has the highest acuity patients (as measured by CMI) in general medicine and general surgery as compared to other Massachusetts academic medical centers (AMCs) and health systems.³⁰ The Applicant states that, for most patients, an extended

²⁵ The Applicant states that industry norms were derived from consultation with health care planners and architects and there are no national or Massachusetts benchmarks. Id. at fn 141.

²⁶ In FY17, 18.4% of BIDMC patient panel encounters were with patients indicating a preference to receive their health care information in a language other than English and that same year, BIDMC responded to 237,256 interpreter service requests. Id. at page 44.

²⁷ In FY17, 350 patient panel encounters were with patients weighing more than 350 pounds, and 64 of these encounters were with patients exceeding 450 pounds. Id. at page 20.

²⁸ From FY15-FY17, 41% of BIDMC's patient panel encounters were with patients who had a primary or co-morbid behavioral health diagnosis. The Applicant states that BIDMC characterizes behavioral health patients as those who have a substance use disorder or mental health disorder as comorbidity. A patient is included in the Behavioral Health Category in a given year if any ICD diagnosis code on a claim (primary or secondary) for any inpatient visit during the years is classified under the Clinical Classifications Software: Mental Illness Level 1 Description. Id. at page 20 and fn39.

²⁹ 0.4% of patients responding to gender identity questions on the BIDMC Medical Practice Survey self-identify as transgender or gender queer and 6.1% responding to sexual orientation questions self-identify as lesbian, gay, or bisexual. Id at page 23.

³⁰ The Applicant states that for CY15, CY16, and CY17, BIDMC had an average case mix index for general medicine of 1.15 and 2.46 for general surgery, which the Applicant states is the highest average CMI among its peer group of academic medical centers (AMCs). General medicine comparators: MGH (1.11), BWH (1.13), BMC (1.13), Tufts

length of stay correlates with complex treatment and care, and that from FY15 to FY17 the total number of BIDMC patient panel encounters with a length of stay (LOS) of 14 days or more increased by 12%, and in FY17, 35% of total beds days at BIDMC were attributed to patients whose length of stay exceeded 14 days.

The Applicant asserts that an increase in patients with behavioral health needs also contributes to the complexity of the BIDMC patient panel and reinforces the need for additional single-bedded rooms to increase available inpatient capacity. According to the Applicant, reduced inpatient bed availability resulting from room blockage increases the time it takes for a patient to transition from the Emergency Department (ED) to an inpatient bed (a time period known as ED Boarding).³¹ The Applicant points to an increase in average ED wait time between FY15 and FY17 from 2.2 hours to 3.3 hours as indication of increasing ED boarding. The Applicant states that ED boarding can result in patient care outside of designated ED bays and cites research stating that prolonged ED wait and length of visit can reduce quality of care and increase adverse events.^{32,33} ED boarding is especially a concern for patients with co-morbid medical and behavioral health diagnoses who, the Applicant asserts, often present for care at the ED. Boarding is stressful and can exacerbate underlying behavioral health issues. The Applicant reported a 14% increase in patients presenting in BIDMC's ED requiring psychiatric consultation between FY15 and FY17, and states that psychiatric consultations contribute to increasing length of stay in the ED. The Applicant asserts that inpatient capacity constraints are reducing access to single-bedded rooms, which offer a quieter, more private, therapeutic environment than the ED.

Need - Perioperative Facilities

The Project will create a new perioperative floor to improve access to and delivery of care for BIDMC's high acuity and aging patient populations. CareGroup asserts that as BIDMC's patient panel grows in complexity so does its need for advanced surgical procedures. CareGroup points to a 27% increase in inpatient surgical procedures since 2016, and an increase in patient volume of complex surgeries from FY15 to FY17.³⁴ The Rosenberg Building, BIDMC's primary inpatient facility on the West Campus, houses multiple operating rooms (ORs) and BIDMC's ED. CareGroup asserts the existing operating rooms cannot accommodate the equipment needed for all types of procedures, and many cannot accommodate developing and future technologies

(1.12), and UMass (1.14). General surgery comparators: MGH (2.41), BWH (2.35), BMC (2.21), Tufts (2.40), and UMass (2.43). DoN Application CG-18051612-HE, Application Narrative, fn56.

³¹ The Applicant states that ED wait time is the average time from physician order (bed request) to bed assignment. DoN Application CG-18051612-HE, Application Narrative, at page 68.

³² Wait time in the work cited refers to the number of minutes between the time the patient arrived at the ED and the time the patient was seen by a provider and length of visit is the number of minutes between the time the patient arrived at the ED and the time the patient was discharged from the ED.

³³ Horwitz, L. I., Green, J., & Bradley, E. H. (2010). United States emergency department performance on wait time and length of visit. *Annals of Emergency Medicine*, 55(2), 131-141. Retrieved September, 2014, from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2830619/pdf/nihms-172790.pdf>

³⁴ The Applicant states that Transcatheter Aortic Valve Replacement surgeries increased by 91% and endovascular surgery increased by 17%.

needed such as advances in minimally-invasive surgery. CareGroup points to a study showing enhanced healing and recovery and shorter lengths of stay associated with minimally invasive surgery and that these benefits extend to older patients.³⁵ CareGroup states that minimally invasive procedures are particularly well-suited for aging patients and for patients with behavioral health co-morbidities who are more susceptible to the effects of sedation. The Applicant asserts that the construction of eight new operating rooms and four new procedure rooms will address challenges presented by the existing surgical suite located in the Rosenberg Building and accommodate the use of the technology that will improve patient recovery and health outcomes.

The Applicant maintains there is need as well to enhance pre- and post-operative/procedure care space within BIDMC to accommodate the additional operating and procedure room capacity and to improve the use of the Rosenberg Building's existing pre- and post-operative care area. The Project will, CareGroup asserts, expand and improve pre and post-operative care areas to make throughput and the delivery of care more efficient. CareGroup describes the current situation which it says will be ameliorated by the construction of additional capacity and enhanced pre-and post-operative/procedure care spaces. CareGroup states that the existing pre-operative/post-operative care in the Rosenberg Building meets the criteria for a combined Pre- and Post-Procedure Area meaning that each of the separate units is suitable for use for both pre and post-operative/procedure care functions as needed. The Applicant states that length of stay in the Rosenberg post-operative care area has increased by 9% between FY15 and FY17 alongside increases in CMI and average daily census. The Applicant asserts that a high inpatient census reduces access to an inpatient bed which increases the length of time a patient remains in the post-operative care area following a surgery or procedure. This lack of availability of an inpatient bed, CareGroup asserts, results in the pre- and post-operative/procedure areas serving as short term holding areas until an inpatient bed is available. CareGroup maintains that slow turnover of patients in the post-operative care area has the potential to delay the start of new cases and creates inefficiencies for medical staff that must travel to different areas of the existing hospital to round on post-operative patients as they are held in this area while waiting for an inpatient bed.

Public Health Value

Public Health Value, for the purposes of DoN, requires that the project have an evidence base, be outcome oriented, and address health inequities. Staff examined the impact of the transaction on improved access to and coordination of care as well as the impact upon outcomes and quality of life.

Single-Bedded Rooms

³⁵ Fan, C. J., Chien, H., He, J., Wolfgang, C. L., Cameron, J. L., Pawlick, T. M., & Makary, M. A. (2018). Minimally invasive versus open surgery in the Medicare population: A comparison of post-operative and economic outcomes. *Surgical Endoscopy*, 3874-3880-. Retrieved September, 2018, from <https://link.springer.com/content/pdf/10.1007/s00464-018-6126-z.pdf>

As noted above in the section on patient panel need, the construction of the NIB will result in the de-doubling of some patient rooms at BIDMC creating added capacity and flexibility to meet patient needs. With single-bedded rooms, all beds will be available at any given time. The additional single-bedded inpatient capacity will reduce the waiting time for patients needing a private room. The Applicant predicts, after completion of the NIB, an occupancy rate of 90% for the M/S beds in single-bedded rooms in the NIB, and 80% for the ICU beds (which are already single-bedded) both working towards what the Applicant argues is an optimal occupancy rate for mixed-bed units of 85%.

The Applicant asserts, with the support of research, that the addition of single-bedded rooms in the NIB will improve the patient experience and enhance general efficiencies;³⁶ and will decrease opportunities for transmission of infection.³⁷ The room size will be increased which, the Applicant states, will facilitate cleaning, and each single-bedded room in the NIB will have a dedicated staff zone in the entryway of patient rooms with a space for donning personal protective equipment. Single-bedded rooms will, CareGroup asserts, provide additional space that reduces the risk of patient falls, a particular concern for BIDMC's aging and behavioral health patient populations. CareGroup cited research for the proposition that reduced noise, stress and confusion, can reduce length of stay and improve the patient experience and health outcomes.^{38,39} The Applicant cites research which associates natural lighting and access to views of nature as beneficial to promoting health and healing,⁴⁰ and states that windows will be located at the end of each floor on the NIB and in every single-bedded room providing patients access to natural light and views of nature.

The Applicant states that single-bedded rooms will improve care for patient populations who often require increased staff and equipment resources to meet their healthcare needs. Applicant points to reporting that states that private rooms align with best practices for transgender care as single-bedded rooms, which do not require gender assignment, will improve access for transgender patients who may delay or avoid seeking medical services when

³⁶ Huisman, E., Morales, E., Van Hoof, J., & Kort, H. (2012, December). Healing environment: A review of the impact of physical environmental factors on users (Rep.). Retrieved September, 2018, from https://ac.els-cdn.com/S0360132312001758/1-s2.0-S0360132312001758-main.pdf?_tid=059696c5-cc9d-46a2-8451-d9e1fdd94dec&acdnat=1541079130_7380d0dbeca058972e8543f554ddec55

³⁷ Separately, the Applicant states that each medical/surgical floor in the New Inpatient Building will have two negative pressure isolation rooms (NPIRs) to reduce the risk of disease transmission. The Applicant states that the limited number of negative pressure isolation rooms (NPIR) results in delays in admission or patient transfers across campus, and between the East and West Campuses, for admission to an available NPIR. The Applicant states that the addition of 15 new NPIRs in the NIB will increase the number of current NPIRs by 45%.

³⁸ Joseph, A., & Ulrich, R. (2007, January). Sound Control for Improved Outcomes in Healthcare Settings (Rep.). Retrieved September, 2018, from Robert Wood Johnson Foundation website: [https://www.healthdesign.org/sites/default/files/Sound Control.pdf](https://www.healthdesign.org/sites/default/files/Sound%20Control.pdf)

³⁹ Tackling Noise In Healthcare Settings. (2018, January 10). Commercial Architecture. Retrieved September, 2018, from <https://www.commercialarchitecturemagazine.com/tackling-noise-healthcare-settings/>

⁴⁰ Huisman, E., Morales, E., Van Hoof, J., & Kort, H. (2012, December). Healing environment: A review of the impact of physical environmental factors on users (Rep.). Retrieved September, 2018, from <https://www.sciencedirect.com/science/article/pii/S0360132312001758>

not provided with a safe and appropriate room assignment.^{41,42} As noted above, the Applicant asserts that the design of single-bedded rooms will support enhanced language access for limited English proficiency (LEP) patients by allowing for the provision of interpreter services in a more convenient and private manner. Single-bedded rooms will provide adequate space to allow for an interpreter to be present with family and medical staff, and will support enhanced interpretation technologies, such as video-enabled services for limited English proficiency (LEP) and Deaf and hard-of-hearing patients.⁴³ In addition to the benefits accruing from creation of single-bedded rooms, the Applicant states that the majority of existing inpatient rooms do not meet patient of size specifications and affirms that following project implementation, all inpatient rooms in the NIB will be large enough to accommodate patients of size and will meet regulatory guidelines for physical room size. Each medical/surgical and ICU floor will have two designated patient of size rooms to meet the care needs of patients weighing over 227 kgs or 500 pounds and that one of the rooms will be a negative pressure isolation room (NPIR) to accommodate advanced clinical needs of patients of size. The increase in available inpatient capacity will also reduce the time it takes patients to transition from the ED to an inpatient room, which will enhance patient flow and quality of care, generally.

The Applicant states that the single-bedded rooms will provide an improved environment for patients to visit with and derive support from their social network. Single-bedded rooms will increase privacy, which the Applicant asserts will improve communication between patients, families and healthcare providers. The rooms will contain features that improve family engagement in patient care, and the size of the rooms will create a more comfortable environment for families and guests to visit patients. The Applicant states that the NIB will include dedicated family zones within the medical/surgical and ICU rooms to allow patients and families a space to spend time together. Patients, their visitors, and staff will also have access to the rooftop healing garden which will, according to the Applicant provide access to daylight, views of nature, and peaceful and quiet outdoor space.

Perioperative Facilities

Improved Operating Room Capacity

The NIB will house eight operating rooms and four procedure rooms designed to address current constraints and limitations on BIDMC's inpatient surgery facilities and improve quality of care for BIDMC's most complex patients.⁴⁴ Operating and procedure rooms will be large

⁴¹ Transgender-Affirming Hospital Policies (Rep.). (2016, May). Retrieved September, 2018, from Lambda Legal website: https://www.lambdalegal.org/sites/default/files/publications/downloads/hospital-policies-2016_5-26-16.pdf

⁴² Transgender is defined to include any person whose gender identity, that is, their inner sense of being male, female, or something else, differs from their assigned or presumed sex at birth. See https://www.lambdalegal.org/sites/default/files/publications/downloads/hospital-policies-2016_5-26-16.pdf

⁴³ The Applicant defines limited English proficient patient and families as those who prefer to receive their healthcare information in a language other than English, and this includes American Sign Language (ASL).

⁴⁴ The Applicant states that the project will result in seven net operating rooms because one operating room in the Rosenberg Building will be eliminated once the NIB is complete to create a connection between the Rosenberg Building and the NIB.

enough to accommodate new technology, permit optimal layout and configuration and improve the flow of patients and personnel through the areas of the surgical suite and procedure rooms. The Applicant states that the NIB will have one or two ORs equipped for performing minimally invasive surgical procedures, a hybrid OR outfitted with imaging equipment and general operating rooms.

The NIB will be arranged in compliance with DPH requirements to limit unrelated traffic through the surgical suite and allow for optimal work zones for all members of the surgical team. The Applicant states that improved OR and support facilities, such as more efficient storage areas for supplies, back-up equipment, and shared equipment, will contribute to a reduction in average OR case length, and increase patient and staff satisfaction. The NIB ORs will accommodate the surgical team, sterile field, and surgical flow. Procedure rooms will be sized to support technological capabilities needed to support complex and advanced cardiac and other procedures. The operating and procedure rooms are designed to accommodate researchers, medical students, and allied health professional trainees to observe and participate in complex operations and the latest innovative techniques, without compromising the surgical team.

Improved Pre/Post-Operative Care

The Applicant states that the perioperative space in the NIB will connect to and integrate with the perioperative floor of the Rosenberg Building resulting in increased pre-operative/procedure capacity, and improved use of the Rosenberg Building's existing combined pre/post-operative care unit. The Proposed Project will create a new, pre-operative/procedure area and the Rosenberg building will become dedicated primarily to post-operative care. The Applicant states that the new pre-operative unit in the NIB is designed to meet the criteria for a combined pre- and post- procedure area as well so that both the NIB and the Rosenberg units will be suitable for use for both pre- and post-operative/procedure functions as needed. This means during times of peak utilization, bays in the pre-operative/procedure unit in the NIB will be used as swing space for post-operative/procedure care and post-operative bays in the Rosenberg Building will be used as swing space for pre-operative care. The Applicant asserts that the NIB will expand the pre-operative and post-operative area; include increased seating and space for family and visitors and private consultation rooms for patient and families to consult with their providers; and will provide access to the Trauma Surgery ICU from the new waiting area eliminating the need for visitors and family members to walk through the pre- and post-operative care area to gain access.

The Applicant asserts that the NIB will operate more efficiently and effectively to provide connectivity to and integration with BIDMC's existing inpatient services. The NIB's pre-operative/procedure care unit will have connections to procedure rooms in the Farr building through the bridge connector between the Rosenberg building and the Farr Building. These connections, the Applicant asserts, will allow patients seen for services in any of these buildings to readily access the entire complex. The connections between the NIB, the Rosenberg Building, and the Farr Building will provide additional operational efficiencies because the buildings will share and utilize existing ancillary clinical support services such as pharmacy, radiology and

pathology and clinical and operational support services. BIDMC's helipad will be relocated to the NIB's rooftop and will the Applicant states, retain efficient access to the Level 1 Trauma Center in the Rosenberg Building. The NIB will also incorporate conference and other education space to facilitate medical education and teaching, and meeting with patients and families. This will allow providers to meet education and teaching obligations and attend meetings without leaving the building. The Applicant states that the Proposed Project will decrease steps in workflow, reduce travel time required of care teams and keep them nearer to their patients, which will improve continuity and coordination of care.

Measurement

The Applicant provided performance metrics to measure the impact of the Proposed Project (Attachment 1). These metrics will become part of the annual reporting on the DoN project.

Competition

The Department can find that the project will be competitive, as that term is used in 105 CMR 100.210(A)(1)(f). Applicant states that in 2016, BIDMC had the lowest average case-mix adjusted cost per discharge of \$8,069 (Massachusetts average was \$11,483). BIDMC's statewide relative price (S-RP) of 1.05, was below the average commercial S-RP (1.17) for academic medical centers (AMCs) in Massachusetts and BIDMC's community hospitals are all below the community hospital cohort average S-RP (1.06) (BID-Milton (0.76), BID- Plymouth (0.87), BID- Needham (0.98)).^{45,46} Based on its own informal data collection, CareGroup asserts that the low ratio of single-bedded patients rooms to double-bedded patient rooms prohibits BIDMC from effectively competing with other AMCs, including higher cost providers. CareGroup states that BIDMC has the lowest ratio of single-bedded rooms to double-bedded rooms as compared to local AMCs which, in turn, creates longer wait times and for patients requiring advanced procedures. CareGroup argues that longer wait times may cause patients to seek care at a more expensive provider in order to receive expedited care. The Applicant argues that with the implementation of the Project, BIDMC will expand patient panel access to its lower-cost providers preventing leakage of patients to higher cost systems and reduce healthcare expenditures overall.

Language Access

Applicant states that patients receiving care in the NIB will have access to BIDMC's interpreter services and notes that single-bedded rooms will make the provision of interpreter services more convenient and private. These services include access to interpreters 24 hours a day seven days a week with interpreters on request for over 70 languages either in person, via phone, or video. Applicant states that interpreters offer in service training to employees and clinical staff to enhance BIDMC's Cultural Competence Initiative. Applicant notes that BIDMC has the longest tenured nationally certified American Sign Language (ASL) Interpreter on staff,

⁴⁵ *Provider Price Variation in the Massachusetts Health Care Market* (Rep.). (2018, April). Retrieved November, 2018, from CHIA website: <http://www.chiamass.gov/assets/docs/r/pubs/18/Relative-Price-Report-2018.pdf>

⁴⁶ Final Calendar Year (CY) 2016 Statewide Relative Price (S-RP) Results. (n.d.). Retrieved November, 2018, from <http://www.chiamass.gov/assets/docs/r/pubs/18/Final-CY16-S-RP.pdf>

along with certified per diem American Sign Language (ASL) Interpreters. Applicant states that BIDMC's existing technological supports including Sorenson videophones installed across its campus to increase communication access for BIDMC's Deaf and Hard of Hearing patients and their families and access to personalized headsets with adjustable volume controls for use by patients admitted to the hospital, will be expanded to the NIB.

Health Equity

The Applicant looked to the BIDMC's 2016 CHNA to understand the health-related issues for populations that face barriers to accessing care and disparities in health outcomes.⁴⁷ Access to care is one of the priorities of the Community Health Implementation Plan (CHIP), BIDMC's structured approach to addressing disparities and inequities identified in the CHNA. The Applicant states that the NIB will increase access to inpatient care for those cohorts identified in the CHNA and represented within the BIDMC patient panel and that the addition of single-bedded rooms will enhance patient-centered care that supports the unique needs of BIDMC patients.

BIDMC serves as a community hospital for residents in surrounding neighborhoods due to its accessibility via public transportation and the Applicant points out both: that the location of the NIB on the BIDMC West Campus will support convenient access for patients in the surrounding areas; and BIDMC's partnership with CCA health centers will support linkages to primary care providers. Applicant also affirms that BIDCO, through participation in the MassHealth ACO Program, will work to increase access to high quality care for residents that are more negatively impacted by social determinants of health. BIDCO will, through its established linkages to primary care providers, improve continuity and coordination of care for BIDMC patients. DPH acknowledges CareGroup's intention to increase access to healthcare for populations identified by BIDMC as demonstrating need for enhanced access to care. To that end, staff recommends that as a condition to any approval of this DoN Application, CareGroup or its successor as Holder, develop a plan to increase health equity; to address disparities; and to increase access (Plan). The condition should require the Holder to demonstrate, through annual reporting, and with the use of data, its commitment to implementation of the Plan and to increasing access to health care at BIDMC.

Community Engagement

Prior to submitting a DoN application, the DoN Regulation requires applicants to have engaged and consulted with the community.^{48,49} The Applicant states that in 2017 and 2018, BIDMC's

⁴⁷ The Applicant states the community benefits service area (CBSA) is a subset of BIDMC's primary service area focusing on the underserved neighborhoods in Boston and Cape Cod correlating with BIDMC's six licensed or affiliated health centers, which serve patient populations of primarily MassHealth enrollees and the uninsured.

⁴⁸ The Community Engagement Guide describes community engagement processes on a continuum from "Inform" and "Consult" through "Community driven-led."⁴⁸ For the purposes of factor 1, engagement defines "community" as the Patient Panel, and requires that the minimum level of engagement for this step is "Consult."

⁴⁹ *Community Engagement Standards for Community Health Planning Guideline* (Rep.). (2017, January). Retrieved May, 2018, from Massachusetts Department of Public Health website:

<https://www.mass.gov/files/documents/2017/01/vr/guidelines-community-engagement.pdf>

senior leadership met on many occasions, with stakeholders, including Community Care Alliance and the Community Benefits Committee to inform the development of the NIB. The Applicant asserts that these discussions reinforced the needs of the BIDMC patient panel that the Proposed Project is intended to address. BIDMC engaged operational support, nurses, physicians, and patients through user groups, to ensure that the building would meet their needs and that data gathered from CHNA sources and stakeholders, BIDMC's Patient Family Advisory Council, BIDMC's Respect and Dignity Initiative, the Universal Access/ADA Staff and Advisory Council, patient complaints, and patient satisfaction surveys, identified the need for greater capacity and improved access, particularly to single-bedded rooms.^{50,51} The Applicant asserts BIDMC is collaborating with community groups, local residents, state and local officials, government agencies, and neighboring institutions and provided a list of organizations in accordance with the requirement for sound community engagement. The Applicant states that BIDMC shared presentations on the Proposed Project at the meetings and the Applicant submitted slides and a sign-in sheet for a Longwood Medical Area (LMA) forum that took place on January 22, 2018. The sign-in sheets indicate 42 people were in attendance at the LMA forum. Organizations represented at the LMA meeting included BIDMC, the Boston Transportation Department, Boston Children's Hospital, Simmons College, Skanska, and Roxbury Tenants of Harvard. BIDMC maintains a New Inpatient Building Project webpage to keep patients, family members, staff, residents, public officials, and community members informed with updates on the project and to act as a means through which BIDMC obtains ongoing feedback and engagement.

Factor 3

CareGroup has certified that it is in compliance and in good standing with federal, state, and local laws and regulations, including, but not limited to M.G.L. c. 30, §§ 61 through 62H and the applicable regulations thereunder, and in compliance with all previously issued notices of Determination of Need and the terms and conditions attached therein.

Factor 4

The DoN regulation at 105 CMR 100.210(A)(4) requires that an Applicant for a DoN provide "sufficient documentation of the availability of sufficient funds for capital and ongoing operating costs necessary to support the Proposed Project without negative impacts or consequences to the Applicant's existing Patient Panel and that the Proposed Project is financially feasible and within the financial capability of the Applicant." Factor 4 requires that the documentation provided in support of the Department's finding shall include an analysis of

⁵⁰ The Applicant states that BIDMC regularly consults with its PFAC which meets every month and the PFAC is engaged in the NIB planning through participation in ongoing committee meetings and user group panels. BIDMC incorporated feedback from PFAC surveys of patients conducted between 2016 and 2017 that compared the experience of patients in single and double-bedded rooms.

⁵¹ The Applicant states that BIDMC regularly convenes a multidisciplinary Respect and Dignity Workgroup comprised of stakeholders from across the medical center that ensures that BIDMC provides a reliable culture of respect and comfort for its patients.

the Applicant's finances, completed by an independent Certified Public Accountant (CPA Report).

The CPA analysis was conducted by BDO USA, LLP and is dated July 26, 2018. BDO analyzed ten year financial projections for CareGroup (Applicant) for the fiscal years ending 2018 through 2027 and supporting documentation to render an opinion as to the reasonableness of the assumptions used in the preparation of the Projections and the financial feasibility of the Project.

BDO analyzed projected revenues, which included net patient service revenue (NPSR), research and other operating revenue for the fiscal years ending 2018 through 2027. BDO states that Management's projected revenues were based on anticipated payer increases, volume increases, case mix index and number of beds for BIDMC (Academic Medical Center, AMC) and its three subsidiary community hospitals. For the AMC portion, Management projected inpatient payer increases of 2.0% per year and outpatient pay increases of 1.5% per year. For the community hospital component, it projected inpatient payer increases of 3.0% per year and outpatient payer increases of 2.0% per year. Inpatient volume growth was projected at between 0.9% and 1.3% annually for both Academic Medical Facilities and Community Hospitals, based on data from a third party consultant and outpatient volume growth between 1.5% and 2.0% annually.⁵² Only the Case Mix Index (CMI) of the AMC, BIDMC, was projected to increase, at 0.6% annually, which BDO found to be reasonable. In determining the reasonableness of the projected revenues, BDO reviewed Management's assumptions, which relied upon historical operations and anticipated market movements. BDO reported that the ten-year compound annual growth rate (CAGR) in the Projections of 3.8% falls below the range of CareGroup's historical revenue growth rate. BDO found revenue growth projections to be a reasonable estimate of future revenues of CareGroup.

BDO's analysis of operating expenses included "salaries and benefits" (60%), "supplies and other expenses" (35.0%), depreciation, and interest. Salaries and benefits were projected to increase approximately 3% annually based on annual merit and market adjustments. Beginning in FY23 through the remainder of the projection period as clinical floors of the NIB project opened, associated incremental direct costs were included. Management expense projections included additional staff and supplies necessary to support the new floors in the NIB and the reopening of a floor on the West Campus. BDO found operating expenses to be a reasonable estimation of future expenses of the Applicant.

BDO reviewed projected capital expenditures related to the proposed project and proposed project financing. For this project, debt financing accounts for 60.0% of the estimated capital expenditures with the remaining 40% financed through contributions. BDO does not expect

⁵² BDO states Mount Auburn Hospital's (MAHs) market share was projected to increase in addition to the growth of 2.0% annually between FY19 and FY23 given the hospital's additional capacity (69.0% in FY17). The additional volume would increase MAH's medical/surgical occupancy to 87.0% in FY2027. DoN Application CG016051612, Application Attachments, CPA Analysis, at page 10.

that BIDMC should have difficulty obtaining the debt financing required. BDO performed a sensitivity analysis assuming the Applicant was only able to raise half of the capital contribution amounts and instead funded approximately 20% based on cash on hand, and BDO found this had no impact on BDO's conclusions on the reasonableness and feasibility of the proposed project.

The Projections exhibit a cumulative operating EBITDA surplus of approximately 6.0% of cumulative projected revenue for the ten years under analysis. BDO noted a decrease in cash in the Projections until the NIB becomes operational (except in FY 2020); however, positive cash flow from operations each year. BDO determined that the anticipated operating surplus is a reasonable expectation and based upon feasible financial assumptions.

BDO determined, "the Projections are reasonable and feasible and not likely to have a negative impact on the patient panel or result in the liquidation of CareGroup."⁵³

Factor 5

Factor 5 requires an assessment of the relative merit of the Proposed Project compared to alternative methods for meeting the patient panel needs. In this context, the Applicant's decision to pursue the Proposed Project was based on an assessment of what would offer optimal operational efficiency, capital investment, and design to support the needs of the patient panel.

The Proposed Project is for the construction of a 10-story inpatient building located on the BIDMC West Campus. Applicant considered two alternatives to the Proposed Project. One alternative proposal was to renovate existing space within BIDMC's existing campus facilities. The Applicant states that BIDMC has the oldest average age of plant in the region (19.2 years in 2017) compared to other systems and DPH licensure requirements call for more square footage for clinical areas than was required when BIDMC's existing facilities were built.^{54,55} The Applicant dismissed the proposal to renovate existing space citing insufficient capacity to stage a cost-effective renovation. According to the Applicant, BIDMC's existing campus buildings are fully occupied and renovating existing BIDMC campus buildings would require multiple, expensive, and disruptive relocations of existing patient services to appropriately size inpatient units and to alter current building infrastructure and utilities to meet Facilities Guidelines Institute guidelines. The Applicant states that existing facilities cannot be renovated to create an equivalent number of single-bedded rooms without significant loss of total medical/surgical beds and reduced clinical capacity and increasing the operating room size in existing facilities would result in a decrease in the number of operating rooms available after the renovation. The

⁵³ DoN Application CG-18051612-HE, Application Attachments, BDO Report at page 46.

⁵⁴ DPH standards are based upon the Facilities Guidelines Institute (FGI) Guidelines applicable to Hospitals and Outpatient Health Care Facilities.

⁵⁵ *Final CMIR*

capital expense and operating costs for this option was not determined because the option was not deemed feasible.

The second alternative the Applicant considered was to build a fully functioning, self-supported medical center that was off the campus of BIDMC to provide inpatient care to the BIDMC patient panel. The Applicant states that an off-campus facility would not be able to fully integrate with the main hospital campus clinical, academic and research programs. Further, building an off-campus facility would require the building of a medical center and all inpatient supporting functions, and the duplicate construction of some of the existing campus support services which the Applicant asserts, does not make this a viable alternative from a costs perspective. The Applicant states that proposed land acquisition that would be a function of this alternative would present time delays and additional costs that were factored into the overall cost analysis. The Applicant predicts the cost of the alternative to be \$1,200,000,000 or twice the cost of the Proposed Project. The high capital expense made this option infeasible so the Applicant did not calculate operating costs.

The Applicant states that the NIB was selected because it was designed and will be implemented to minimize capital expenditures and leverage existing space to make care delivery more efficient. The NIB will be constructed on existing BIDMC property adjacent to other inpatient facilities allowing BIDMC to leverage existing buildings, services and functions on the West Campus. The Applicant asserts that the integration that will be achieved through the NIB will reduce provider travel time between patient care, medical education and teaching, and will allow for the movement of patients between BIDMC buildings. The Applicant states that the Proposed Project does not require demolition of existing buildings, major disruption of existing services, or acquisition of land, which reduces capital expenditures required to complete the project. Additionally, of the options explored, the NIB was the shortest time to complete. The NIB's flexible design will enable BIMC to renovate existing clinical floors and procedural suites more efficiently in the future, will allow for reallocation of service lines to different floors with minimal effort, and the similar layout of the floors will allow physicians and staff to navigate each floor with familiarity enhancing operational efficiency. The Applicant asserts that the site of the NIB is the most cost-effective of all the options considered.

Factor 6

Background

The Community Health Initiative (CHI) component of the DoN regulation requires approval of the Applicant's plans for fulfilling its responsibilities set out in the Department's Community-based Health Initiatives Guideline (Guideline). This is a Tier 3 project, which applies to projects with a CHI contribution greater than \$4,000,000. The Applicant is required to and did submit documentation showing that the existing community health needs assessment (CHNA) and community health improvement planning (CHIP) processes both evidence a sound community engagement process and demonstrate an understanding of the DoN Health Priorities sufficient for selecting strategies to fund and implement following approval of the DoN project (this

means submittal of a CHNA-CHIP Self-Assessment, Stakeholder Assessments and the most recently completed community health needs assessment). Tier 3 Applicants are further required to submit a Community Engagement Plan at the time of application because the Guideline states that additional community engagement must take place to develop issue priorities prior to submitting the Health Priorities strategy selection form to DPH. In this case the Applicant did submit a Community Engagement Plan.

In making its recommendation to the Department, DPH staff may require corrective actions or steps to be taken based on the information provided by the Applicant which will become conditions of approval. For Tier 3 Applicants the Community Engagement Plan and the actions described in that Plan become conditions of approval.

If the DoN is approved by the Department, the Applicant (then Holder of a DoN) will work with its CHI Advisory Committee (which needs to meet the Departments standards) to complete any additional community engagement requirements and select Health Priority strategies for funding and implementation from the existing CHNA/CHIP or other assessments as required by the Department. These processes, selection of the Health Priorities and funding decisions, are conditions of the DoN and enforceable as such.

This Application

The Applicant submitted the following: a CHNA/CHIP Self-Assessment, 7 Stakeholder Assessments, and a Community Engagement Plan describing actions for all 5 stages of the CHNA/CHIP cycle, and the 2016 Beth Israel Deaconess Medical Center Community Health Needs Assessment. Staff from DPH's Office of Community Health Planning and Engagement as well as 3 members from DPH's Cross-Bureau Community Engagement Workgroup conducted the review of these materials. Summary review comments provided to the Applicant and the Applicant responses are included as Attachment 2

Of primary importance for Public Health Council review is to note that DPH is requiring that CHI decisions be made as part of the 2019 CHNA cycle and that the Applicant will not be using the 2016 CHNA as a foundation for CHI decisions. At the time of this Application there was not enough detail about the 2019 CHNA/CHIP process known to include full details in the submitted Community Engagement Plan (CEP) and accordingly DPH will be requiring the submission of a revised CEP to be submitted and that will be based on and coordinated with the community engagement activities planned for the 2019 CHNA/CHIP. For brief context regarding this decision, the hospitals comprising the Consortium of Boston Teaching Hospitals (COBTH) are conducting a joint CHNA/CHIP process (for the first time) which will be completed by September 2019. DPH is highly supportive of joint CHNA/CHIP processes in similar geographies and believes this represents the best opportunity for both leveraging CHI resources across health systems and to leverage and coordinate related community engagement activities. The CEP submitted at the time of application is provided as a reference and for informational purposes only as Attachment 3. It is anticipated that the full methodology for the joint CHNA/CHIP, including all plans for community engagement, will be known by the end of January 2019. The revised CEP will then be completed in collaboration with the Applicant's

Community Advisory Committee and will leverage and work with the community engagement activities of the joint CHNA/CHIP.

Finding and Recommendation

The Applicant provided evidence to support the assertion that the construction of a New Inpatient Building on BIDMC's West Campus will increase access to high-quality, patient-centered care in a lower-cost setting. The Applicant maintains that the Proposed Project will improve the patient care experience and health outcomes, increase operational efficiencies and align with the Commonwealth's goals for cost containment, which, with the recommended Condition 8, below, supports the Applicant's compliance with factors 1 and 2.

In addition, the Applicant is in compliance with factor 3. Based upon the CPA analysis, the Proposed Project is financially feasible in the context of factor 4. Construction of a new inpatient building on the BIDMC West Campus is, on balance, the superior alternative for meeting the existing Patient Panel needs from the perspective of quality, efficiency, and operating costs as required by factor 5. Finally, the Applicant is in compliance with the requirements of the CHI planning process for the purposes of factor 6, subject to the CHI Conditions and Timeline and pursuant to 105 CMR 100.310(J).

CHI Conditions to the DoN

1. Of the total required CHI contribution of \$29,678,038, a total of \$7,419,509 will be directed to the CHI Statewide Initiative and \$22,258,529 will be dedicated to local approaches to the DoN Health Priorities. The local approaches amount includes an agreement that up 10% of these resources be available for evaluation, \$593,561 be allowed for administrative purposes (as allowed by the CHI Guideline) and to be used for the activities described in Exhibit D, which include strategies to address barriers to participation in community engagement activities, as well as up to \$250,000 over the course of the CHI project for independent facilitation of advisory committee meetings. To comply with the Holder's obligation to contribute to the Statewide CHI Initiative, the Holder must submit a check for \$7,419,509 to Health Resources in Action (HRiA) (the fiscal agent for the CHI Statewide Initiative). The Holder must submit the funds to HRiA within one month from the date of the Notice of Approval. The Holder must promptly notify DPH (CHI contact staff) when the payment has been made.
2. The Applicant will notify DPH when the community engagement plans for the joint CHNA/CHIP are completed and will submit a revised Community Engagement Plan after that date. All activities described in the revised Community Engagement Plan to be submitted and approved by DPH are considered conditions of approval.
3. Funds will be distributed over a period of time that is subject to final choice of Health Priority strategies, final program approval and based on the CHI Timeline that will be submitted at the time the revised Community Engagement Plan is submitted.

- The revised timeline will include the date by which the Health Priority Strategy Selection form is submitted to DPH. .
4. The revised Community Engagement Plan will include a new advisory committee member representing the Transportation and Planning sector.
 5. The 2019 Collaborative CHNA/CHIP that the Applicant is participating in will include an analysis of social determinant of health information consistent with DPH's Health Priorities and the 2019 CHNA/CHIP will be the basis for choosing funded strategies.

Other Conditions to the DoN

6. In its first report mandated by 105 CMR 100.310(L), the Holder will provide the following:
 - a. A report that details, for each measure set out in the Assessment Tool (Attachment 1):
 - i. the baseline measures
 - ii. expected benchmarks;
 - iii. measure specifications; and
 - iv. the anticipated time to meet benchmark
7. For the duration of the reporting period mandated by 105 CMR 100.310 (L) and this Notice of DoN, the Holder will provide the following:
 - a. A report on the measurable achievement toward the measures set out in Attachment 1.
8. With its first report mandated by 105 CMR 100.310(L), the Holder shall submit a plan, subject to Department approval, through which the Holder will increase health equity; address disparities; and increase access at BIDMC (Plan).
 - a. The Holder shall update this Plan through annual reporting, with the use of data, evidencing its commitment to implementation of the Plan and to increasing access to health care at BIDMC.

In compliance with the provisions of 105 CMR 100.310(L) and (Q), which require a report to the Department, at a minimum on an annual basis, including the measures related to achievement of the DoN factors for a period of five years from completion of the project, the Holder shall address its assertions with respect to the improved health outcomes resulting from the Proposed Project and that BIDMC will remain a lower-cost alternative for high-quality care.

Based upon a review of the materials submitted, and subject to the Conditions set forth herein, Staff finds that the Applicant has met each DoN factor and recommends that the Department approve this Determination of Need application for the construction of New Inpatient Building subject to all standard conditions (105 CMR 100.310).

Attachment 1

1. Reduction in average daily blocked beds
 - a. Measure: Average daily census of blocked beds (All services)
 - b. BIDMC Target for Year 2 of Project
 - i. Ongoing measurement and improvement
2. Improved optimal occupancy rates
 - a. Measure: Occupancy rates
 - b. BIDMC Target for Year 2 of Project
 - i. Medical/Surgical (in NIB) - not to exceed 90%
 - ii. Medical/Surgical (remainder of BIDMC campus building) – not to exceed 85%
 - iii. ICU (All BIDMC) - not to exceed 80%
3. Reduced Emergency Department boarding
 - a. Measure: ED wait times (Physician order to bed assignment)
 - b. BIDMC Target for Year 2 of Project
 - i. Continued Improvement
4. Increased patient satisfaction scores
 - a. Measures:
 - i. Hospital Environment Quiet & Cleanliness
 - ii. Patient Rating of Hospital
 - iii. Whether patient would recommend hospital to others
 - b. BIDMC Target for Year 2 of the Project
 - i. 1% improvement, above the scores in the twelve-month period immediately preceding the occupancy of the New Inpatient Building patient bed floors, and maintaining this improved satisfaction level in subsequent years
5. Reduced incidence of patient falls
 - a. Measure: Patient falls with injury (per 1,000 days)
 - b. BIDMC Target for Year 2 of Project - Represents peer group average
 - i. Adult Medical < 0.65
 - ii. Adult Medical Surgical < 0.50
6. Reduced risk of hospital-acquired infections
 - a. Measure - MRSA Blood Infections
Clostridium difficile Intestinal Infections
 - b. BIDMC Target for Year 2 of Project
 - i. Continued measurement
7. Case Mix Index
 - a. Measure – Annual Case Mix Index (including the absolute change in CMI from the prior year, the percentage change in CMI from the prior year, and key diagnosis groups and/or service lines most responsible for changes in CMI).
 - b. BIDMC Target for Year 2 of Project
 - i. None specified

BIDMC will measure and report on the 12 month period that commences at the beginning of the 13th month after the New Inpatient Building Project is fully operational.



Beth Israel Deaconess
Medical Center



HARVARD MEDICAL SCHOOL
TEACHING HOSPITAL

To: Ben Wood, Director, Office of Community Health Planning and Engagement,
Massachusetts Department of Public Health

From: Nancy Kasen, Director of Community Benefits, Beth Israel Deaconess Medical Center

Re: Massachusetts DPH DoN Application Number: CG-198051612-HE (the "Application")
DPH September 20, 2018 Email Request for Additional Information regarding the BIDMC
Community Engagement and Community-based Health Initiatives (CHI)

Date: October 8, 2018

In response to your email referenced above and pursuant to our conversation of September 25, 2018, this memorandum includes Beth Israel Deaconess Medical Center's ("BIDMC") responses to the Department's request for additional information regarding the BIDMC Community Engagement Plan and Community-based Health Initiatives (the "Request"). The full text of the Request is attached as Exhibit A, and we have reproduced below verbatim the "Questions/Comments and Requests for Additional Information from the Committee Review" listed in your email Request and have provided our responses after each item. We also have included content and cross-references throughout our responses to reflect where such information further supplements the Community Engagement Plan ("CEP") and related attachments that we submitted as part of the Application. BIDMC appreciates this opportunity to answer your questions about our Application materials concerning community engagement and community-based health initiatives and looks forward to the full launch of this endeavor.

Item 1:

Questions/Comments and Requests for Additional Information from the Committee Review:

- ***Questions about the upcoming 2019 CHNA/CHIP cycle: The committee was interested in learning more about how BIDMC is thinking about the 2019 CHNA cycle and what from that process could be leveraged to assist with DoN-CHI community engagement? We would like to see these connections made more explicit in the Community Engagement (CE) Plan to the extent that is possible and with current knowledge about engagement processes for the joint COBTH CHNA/CHIP. Please note that the CE Plan becomes a formal reporting tool so the more detail that is included the easier it will be to follow. We also recognize that the advisory committee(s) will and should play a role***

in community engagement and that it may change as a result of the committee's feedback."

Item 1 – BIDMC's Response:

The Boston CHNA CHIP Collaborative ("The Collaborative") was formed by members of the Conference of Boston Teaching Hospitals "(COBTH)", of which BIDMC is a member, together with the Boston Public Health Commission, community health centers, and other community voices. On September 17, 2018, The Collaborative launched the joint CHNA/CHIP. BIDMC is enthusiastic about the opportunities that will be presented to incorporate and integrate The Collaborative's efforts into our proposed methodology for the DoN-CHI community engagement. Likewise, the work of The Collaborative will inform the hospital's FY 2019 Community Health Needs Assessment report and corresponding Implementation Strategy. This coordination and integration of efforts will be streamlined since BIDMC's Director of Community Benefits, Nancy Kasen, serves as a founding member and now Co-Chair of The Collaborative's Steering Committee. We eagerly anticipate forging close connections with The Collaborative's community engagement processes and leveraging its work to assist with the New Inpatient Building DoN-CHI community engagement through the following community engagement strategies and health priorities:

- BIDMC will actively participate in and implement the strategy outlined by The Collaborative's Community Engagement Workgroup. BIDMC's CHI Manager, once hired, will serve on The Collaborative's Community Engagement Workgroup. BIDMC will ensure proper transparency by sharing The Collaborative's community engagement strategy with the New Inpatient Building Community Advisory Committee (the "NIB-CAC"), BIDMC's designated DPH CHI-Advisory Committee, through distribution of meeting minutes and other informative materials.
- While The Collaborative is developing its initial focus and the list of questions to be employed in its collection efforts, BIDMC will work to balance the NIB-CAC's need for specific information by promoting tailored data gathering questions for defined sub-cohorts and in-depth questions on specific issues/priorities. In remaining supportive of The Collaborative's pilot efforts and respecting the autonomy of both the NIB-CAC and The Collaborative, BIDMC will cross-walk mutual efforts when appropriate.
- BIDMC will work with the NIB-CAC to participate in The Collaborative's primary data collection. As outlined in Section I of Application Attachment I.2, "BIDMC Supplemental Information to the Community Health Initiative Community Engagement Plan Form," ("CEP Supp") and specified in the NIB-CAC Charter which is being included as part of this

Response¹, one of the many responsibilities of the NIB-CAC members is to assist BIDMC with community engagement, specifically focusing on hard-to-reach individuals who would most benefit from the CHI funds and programming. As stated in the CEP Supp, NIB-CAC members are expected to attend at least one community forum or other primary and qualitative data collection effort, to promote increased synergy between the NIB-CAC and The Collaborative.

- NIB-CAC members will be asked to fulfill their community engagement responsibilities associated with The Collaborative’s data collection efforts in (a) the five BIDMC Community Benefits Services Area (“CBSA”) Boston neighborhoods identified within the CEP of Allston/Brighton, Bowdoin-Geneva, Chinatown, Fenway/Kenmore, and Roxbury and/or (b) with the targeted cohorts specified in BIDMC’s latest Implementation Strategy – low-income, racially/ethnically diverse, older adults, and lesbian, gay, bisexual and transgender (“LGBT”) populations.
- The NIB-CAC also may supplement The Collaborative’s primary data collection efforts in these neighborhoods or with these specific cohorts. Additionally, due to changes to BIDMC’s CBSA beginning with the FY 2019 CHNA, for the New Inpatient Building DoN CHI, BIDMC will initially focus on the overlapping portions of its old and new CBSA – the five Boston neighborhoods mentioned above.² As provided in the CEP, given BIDMC’s historic focus on and continued commitment to the under-served, BIDMC will focus the CHI on those communities and neighborhoods within its CBSA that face the greatest health disparities. As BIDMC’s new CBSA includes the underserved community of Chelsea, BIDMC is working to identify a representative from the Chelsea Health Department to serve on its NIB-CAC.
- While engaging in ongoing dialogue with the community, as discussed in the CEP Supp, BIDMC will share any additional primary data collection efforts directed by the NIB-CAC with The Collaborative and relevant community-based organizations. As part of the BIDMC New Inpatient Building DoN CHI process, BIDMC plans, as appropriate, to augment the proposed 15 focus groups, 9 forums and 25 informational interviews planned by The Collaborative to focus on the neighborhoods and specific cohorts and needs within BIDMC’s CBSA. Unless directed otherwise by the NIB-CAC, BIDMC will use the similar methods and questions employed by The Collaborative.

The detailed CHI Budget is attached as Exhibit C. The amounts proposed for these neighborhoods and/or specific community cohorts and the corresponding outreach and data collection strategy are delineated in the CHI Budget. Given that this is the pilot year for The

¹ The NIB-CAC Charter is discuss in BIDMC’s response to Item 3.B below and is attached as Exhibit B.

² BIDMC’s new CBSA will include the following neighborhoods: Allston/Brighton, Bowdoin-Geneva, Chinatown, Fenway/Kenmore, Roxbury, Chelsea, Lexington, Needham, and Chestnut Hill.

Collaborative, some of its efforts will be focused on forming its structure, composition, and infrastructure during the needs assessment and prioritization process. If DPH and the NIB-CAC are amenable, BIDMC would explore the possibility of using CHI funds to develop resident and stakeholder capacity to conduct primary and qualitative data collection. The use of CHI funds to build community-based capacity at the grass-roots level will accomplish several longer term goals:

- Strengthen the community’s engagement and investment in the process by fostering buy-in and ownership of the process;
- Increase the likelihood of tangible impact on community health by investing in community engagement activities at the grass-roots level;
- Help facilitate access to hard-to-reach cohorts and marginalized populations, such as limited English proficient and transgender/gender-diverse populations;
- Build skills and social capital of stakeholders; and
- Increase the potential long term sustainability of The Collaborative.

It is important to highlight that the timing between The Collaborative’s primary data collection, community engagement and the initial deadline for disbursing CHI funds into the community may not align. The Collaborative will be conducting its primary data collection/community engagement from November 2018 through February 2019, with the data analysis targeted to be available one month later, in March 2019, which is an ambitious goal. The deadline under the DoN program for getting the first round of funding into the community is within 6 to 12 months after the Notice of Determination of Need which is anticipated to be before the end of 2018 based on a standard 120 day approval timeline. BIDMC is prepared to work with DPH to ensure that all CHI requirements are met in a timely manner while not over-burdening community members by conducting sequential engagement processes for overlapping and parallel needs assessments.

Item 2:

Questions/Comments and Requests for Additional Information from the Committee Review:

- ***Background question regarding the cycles of community health improvement planning: The committee is interested in understanding more about how/if BIDMC views the cycles of CHNAs as continuous improvement planning processes. We see this as important in understanding how you think about building on past investments/successes to inform how the DoN-CHI decisions will be made/implemented/evaluated. Please briefly describe how the DoN-CHI will fit into a***

continuous process that includes how community benefit determinations and programs work.

Item 2 – BIDMC’s Response:

BIDMC’s Community Benefits program is driven by the triannual CHNA and Implementation Strategy process mandated by federal law. The FY 2019 CHNA will be BIDMC’s third health needs assessment since the 2012 effective date of the Affordable Care Act provision enacting Section 501(r) of the Internal Revenue Code and its accompanying regulations. Each CHNA and strategy cycle presents an opportunity to build and improve upon the last.

In FY 2013, BIDMC’s first CHNA under the new IRS requirements, given the limited availability of timely secondary data and desire to obtain comprehensive information from the community, BIDMC conducted its primary data collection by fielding a comprehensive 60+ question survey translated into six different languages and convening several focus groups. Although the effort produced over 740 completed surveys, this process yielded limited information by sub-cohort or specific neighborhood and was resource intensive and not cost-efficient.

Building upon the experience and insight gained from the FY 2013 CHNA, in FY 2016, BIDMC changed its primary data collection methodology to community forums. BIDMC’s most promising forums were those held in the community in collaboration with community-based organizations, including health centers and other hospitals. The success of this effort is largely due to the leveraged use of existing meetings/gatherings of these organizations in order to facilitate increased access and participation.

As BIDMC’s CHNA and community benefit processes have evolved, so have our implementation strategies, as exemplified below:

- Following the FY 2013 CHNA in an effort to build social capital and encourage the growth of community residents in the Bowdoin-Geneva neighborhood, BIDMC provided funds³ to the Boston Alliance for Community Health to develop and mentor a Community Advisory Board (“Bowdoin-Geneva CAB” or “CAB”). The Bowdoin-Geneva CAB was trained on writing RFPs and evaluating proposals with the objective that the CAB would self-direct community grants to individuals or organizations working to address the Bowdoin-Geneva’s community’s needs – including job readiness, employment, economic stability, violence prevention, healthy eating/active living. BIDMC believes elements of this model, with some modifications such as stipends for

³ Funds were provided from a small 2013 DoN, together with matching BIDMC Community Benefits funds.

participating residents, are worthy of being considered to be re-deployed in the CHI as further described below.

- BIDMC also has awarded grant dollars following a request for proposals process, and this approach has allowed BIDMC to expand the number of collaborators with which it works in the community. BIDMC has made conscious efforts to branch out beyond longstanding, stable community groups when awarding funding. It is important to note that this approach has met with some mixed results that are unrelated to BIDMC's involvement. When lesser known entities were involved, post-award programming, was not always sustained and collaborative initiatives among independent community organizations and residents have ceased to continue despite BIDMC's willingness to provide funding, support or collaborate. In an effort to have more impact with scarce resources, BIDMC's current strategy entails working with more established organizations including the Boston Public Health Commission, and the five independent and one BIDMC-licensed community health center, among others, to implement or support sustainable programs, which, depending on grant structure and requirements, has the potential to facilitate building the capacity of less established community organizations through partnership.
- In addition to working directly in the community and providing grant funding, BIDMC collaborates with other organizations across the City. BIDMC participates on several collaborative efforts with established community partners, such as the COBTH initiative to form The Collaborative, as well as, the Boston Area Collaboration on the Social Determinants of Health group. Since 2017, BIDMC has been participating and provides financial support for the Boston Area Collaboration on the Social Determinants of Health (SDOH) group. This group collaborates around SDOH, working to identify key shared domains, fostering best practice opportunities related to resource investment, engaging in dialogue to identify opportunities for advocacy and strategies related to policy and program development.
- BIDMC's Community Benefits program also has had some success with targeted funding opportunities where BIDMC has worked with the Boston Public Health Commission ("BPHC") to implement programming related to community-building. The recent Safe-Routes-to-School collaboration was one such program which resulted in uniquely designed bike racks at Boston Public Schools within BIDMC's CBSA. In addition, high school students who participated in the program with Artists for Humanity were able to build their individual portfolios and received compensation for their work.
- As specified in the DPH DoN guidelines, the NIB-CAC will determine the priorities and the categorical allocation of funds. BIDMC remains committed to trying new and innovative methods to build the social capital of underserved communities and cohorts. Continuing its current practice, BIDMC will use Community Benefits funding to continue

to run its existing Community Benefits programming and support the overall health of cohorts prioritized in its Implementation Strategy and will continue to seek opportunities and ideas, informed by the CHI process, to provide smaller grants or seed grants to organizations/community initiatives that show promise. Such an example includes BIDMC's recent grant to the Bowdoin Geneva Alliance ("BGA"), a collaborative of neighborhood organizations that works together to resolve the complex issues of the Bowdoin-Geneva neighborhoods. Building on the prior experience with the Bowdoin-Geneva CAB mentioned above, BIDMC met with members of the BGA to determine ways the BGA could develop and deploy its efforts to strengthen its neighborhood's social capital. BIDMC recently provided a grant to the BGA to initiate and undertake a strategic planning process over the next nine months. Using one lesson learned from the Bowdoin-Geneva CAB initiative, the BGA grant includes funds for resident stipends to incentivize engaged and sustained participation.

In furtherance of our efforts to leverage resources, a city-wide CHNA holds the promise of a more engaged, collaborative process that ultimately, over time, may increase the likelihood of sustainable change. BIDMC's desires to improve community health, engage community residents, and structure our Implementation Strategy to address identified health needs using a comprehensive, consensus-driven approach. This has been the primary motivation for BIDMC's Director of Community Benefits to lead efforts, along with other COBTH members and the Boston Public Health Commission, for the past several years, to build the structure for The Collaborative. As described above in our response to Item 1, BIDMC would encourage the use of its CHI funds to build grass roots capacity to conduct primary data collection going forward. In addition, working with and building upon the collective efforts of The Collaborative, in the FY 2019 CHNA, BIDMC intends to conduct a prioritization process – both through The Collaborative and for its institution specific Implementation Strategy.

These and other efforts to date will inform and foster successful implementation of the CHI, and BIDMC remains deeply committed to and invested in building the capacity and social capital of the neighborhoods and underserved cohorts who face the greatest health disparities, within its CBSA. BIDMC believes the relationship of CHI funds and existing Community Benefits programming to be synergistic. If agreed upon and directed by the NIB-CAC, CHI funds will provide the opportunity to move further upstream and address the root causes of poverty – such as educational attainment, housing instability, and economic stability.

Item 3:

Questions/Comments and Requests for Additional Information from the Committee Review:

- ***As a general comment, a common response from reviewing all the materials concerning community engagement was that quality of engagement ought to also be highlighted in the application materials and considered in the process in addition to quantity, i.e. number of activities, people engaged, etc. Describing quality of engagement involves both A) the types of people engaged as well as the B) opportunities for engagement. See “A” and “B” below for detail and direction for responding to this issue.***

Item 3 – BIDMC’s Response:

BIDMC recognizes the need for both quantity and quality of engagement. As outlined above regarding our continuous quality improvement efforts related to our CHNA and Implementation Strategies, we continue to work to effectively engage residents, community members and those most challenged by health inequities.

Item 3.A:

A. *Committee review comments regarding types of people/organizations that have been/will be engaged*

The committee noted a heavy emphasis on the use of community health centers for engagement. The committee members expressed some concern about an over reliance on engaging the leadership at the health centers who have a financial relationship with BIDMC. We certainly believe and understand the importance of working with and through pre-existing relationships and organizations that have connection to the community. However, ideally, people experiencing inequities, i.e. resident level engagement, would be more engaged in the process of determining the issues and solutions to address inequities. Furthermore, the committee noted that they would like to see more explicit description of how barriers to engagement are and will be addressed. In other words, please describe how you intend to make your engagement processes more accessible to a wide audience. Please consider this in your responses to opportunities you see with leveraging and coordinating with the joint CHNA/CHIP.

Likewise, it was unclear who was engaged at which phase of the engagement process (e.g. the CHNA/CHIP cycles). For example, the committee was confused how the Outer Cape Health Center was engaged throughout the process. While the committee understood that it is in the NIB-CAC, they didn’t seem to be included in the CHIP and therefore the CHI catchment area. Due to possible changes in BIDMCs community benefits service area we think it’s important to be explicit and transparent about who

is engaged and for what purpose (please remember the CE Plan becomes a public record).

Lastly, the committee noted that there doesn't seem to be any evaluation of engagement processes. Please describe in more detail how you are thinking about evaluating community engagement in addition to evaluation of strategy implementation.

Item 3.A – BIDMC's Response:

Note: There are several questions and requests embedded in Item 3.A. For clarity, BIDMC has organized its response to this item as answers to individual questions and requests compiled from the item, as listed below.

Who was engaged and at which phase of FY 2016 CHNA/CHIP the engagement process?

BIDMC conducted a three-phased iterative community health needs assessment process for the FY 2016 CHNA/CHIP, where key informant interviews were conducted at the start of Phase I to determine key health concerns, social needs, and most concerning health and social challenges. Additionally, information was sought to understand existing strength and community assets to address these concerns, including brainstorming for additional ideas on programming and resources. The following list identifies key informants with which the above topics were discussed:

	Name	Title and Affiliation
INTERNAL	Marsha Maurer	SVP, Patient Care Services & Chief Nursing Officer
	Ken Sands, MD	SVP, Health Care Quality & Chief Quality Officer
	Jayne Sheehan	SVP, Ambulatory and Emergency Services & System Clinical Integration
	Barbara Sarnoff Lee	Director, Social Work
	Kate Reed	SVP, Clinical Program Strategy and Planning
	Sarah Moravick	Quality Improvement Project Manager
	Dr. Alan Abrams	Medical Director, BIDCO

	Name	Title and Affiliation
EXTERNAL	David Aronstein	Program Director, Boston Alliance for Community Health
	Huy Nguyen	Executive Director/Medical Director, Boston Public Health Commission
	Gerry Thomas	Director of Community Initiatives, Boston Public Health Commission
	Adela Margules	Executive Director, Bowdoin Street Health Center
	Phyllis Barajas	Chair, Community Benefits Committee
	Matthew Epstein	Former Chair, Community Benefits Committee
	Paula Ivey Henry	Community Benefits Committee/HSPH
	Ben Wood	Director, Office of Community Health Planning and Engagement, Mass Department of Public Health
	Amanda Cassel Kraft	Chief of Staff, Assistant Secretary of EOHHS/Medicaid
	Henia Handler	Director of Government Affairs, Fenway Health
	Eugene Welch	Executive Director, South Cove Community Health Center
	Eric Tiberi	Chief Operating Officer, South Cove Community Health Center
	Elmer Freeman, MSW	Executive Director, Center for Community Health Education Research and Service, Inc., Director of Urban Health Programs and Policy, Northeastern University

BIDMC continued its engagement through Phase II by conducting the following community forums. Several of these forums were conducted in collaboration with other hospitals, health centers, and community-based organizations. These community forums included a presentation of secondary and primary data and were followed by an independently facilitated discussion around health and social needs, resources and assets, barriers to health and wellness and prioritization of the most pressing health and wellness issues. These forums included representation from community-based organizations and residents, as shown below:

Date	Forums	Audiences
3/8/16	BIDMC Community Benefits Committee	BIDMC Internal Staff Community Leaders and Advocates
3/3/16	Bowdoin-Geneva Alliance Community Advisory Committee Meeting	Health and Social Service Providers Community Leaders and Advocates Community Residents
3/8/16	Chinatown/South End Community Forum	Health and Social Service Providers Community Leaders and Advocates Community Residents
5/12/16	Outer Cape Community Forum	Health and Social Service Providers Community Leaders and Advocates Community Residents
3/1/16	Quincy Community Forum	Health and Social Service Providers Community Leaders and Advocates Community Residents
3/16/16	Roxbury Community Forum	Health and Social Service Providers Community Leaders and Advocates Community Residents

Who is currently engaged in the process of determining the issues and solutions to address inequities?

The NIB-CAC Charter, as outlined in Exhibit B, both with respect to (i) the composition of the NIB-CAC with representation from our CBSA as described in Item 1 above with strong community health center engagement, and (ii) the inclusive operating procedures of the committee, reflects BIDMC's commitment to fostering a broad and inclusive community-based NIB-CAC with participants representing a multiplicity of perspectives and coming to the table with differing levels of empowerment and expertise. BIDMC's hope is that the composition and structure of the committee itself will inspire higher levels of community engagement. This is because the NIB-CAC Charter reflects internal committee transparency both in membership and in processes lending credibility and fostering buy-in to the NIB-CAC's efforts. For example, the NIB-CAC membership includes residents and patients, and there will be a public comment portion at NIB-CAC meetings. In addition, NIB-CAC members are obligated to disclose potential financial and other conflicts of interest -- both upon joining the NIB-CAC and in connection with priority setting allocations decisions. The NIB-CAC members will be charged with reviewing and adopting the drafted charter document based on their input and priorities, a process consistent with the inclusiveness of the committee itself. The use of an independent facilitator is being

proposed to maximize dialogue and engagement through inclusion of all participants, during community forums and the public comment portion of each NIB-CAC meeting.

How was the Outer Cape Health Center engaged throughout the process?

BIDMC has long-standing, deep collaborative roots in its CBSA. The Cape Cod towns were originally included in the CBSA because BIDMC has an affiliated health center on the Outer Cape. As with all of our health centers, we consulted with Outer Cape for our community health needs assessment. Physical distance presented some difficulties to the engagement process on the Outer Cape. In compliance with the final 501(r) requirements, BIDMC's Community Benefit Committee voted to change BIDMC's CBSA, beginning with the FY 2019 CHNA, to include the five Boston neighborhoods, Chelsea, Chestnut Hill, Lexington, and Needham. BIDMC remains committed to the under-served populations and individuals facing the greatest health disparities. BIDMC continues to support Outer Cape as a member of the Community Care Alliance and their efforts, as discussed below.

Describe resident level engagement in the process of determining the issues and solutions to address inequities.

BIDMC's Community Engagement Plan submitted with the Application details a history of BIDMC's deeply-rooted relationship with the community health centers and demonstrates how BIDMC's health center network is the core of its Community Benefits program. BIDMC has been working with health centers, their patients, and their consumer-majority boards of directors for fifty years. BIDMC supports the Community Care Alliance health centers and their focus on the underserved as they serve as the cornerstone of the communities in which they are located. The leaders of the health centers are in the best position to engage and leverage the resources and capabilities within their organizations and communities, and serve as a lynchpin to residents, patients, community members and other organizations with which they partner. The health centers focus intensely on the social determinants of health to achieve health equity for their communities. Each health center in the Community Care Alliance, as described below, serves a unique community and/or sub-cohort that faces barriers to achieving health equity. The leaders of these organizations understand and have seen first-hand, for many years, the effects that poverty, discrimination and lack of resources have on their communities. The health centers and their staffs have meaningful relationships with many members of the communities and patient cohorts they serve. As such, each brings the voice of the voiceless to the NIB-CAC, and they will be able to help ensure that the CHI community engagement process connects with a wide group of individuals who are underserved.

South Cove Community Health Center – serving patients from over 300 different zip codes, South Cove is uniquely positioned to understand and provide insight into the needs of the Asian

community, a population for which secondary data, and often primary data, can be difficult to obtain and is challenging to analyze. South Cove leadership, including consumers from their Board of Directors, has been instrumental in ensuring culturally appropriate maternal/child health and cancer screening, prevention and access to care. They also have on-site WIC and Early Intervention programs serving the full life continuum.

The Dimock Center⁴ – delivering comprehensive health and human services in an urban community, for the past 156 years, and providing the Roxbury community with convenient access to high quality, low cost health care and access to other important human services that might not otherwise be available to the communities it serves. Dimock is a comprehensive behavioral health care provider offering mental services, and substance use disorder treatment through The Dr. Lucy Sewall Center for Acute Treatment Services. Dimock is also a full social service agency known throughout the Commonwealth for its campus programs including Head Start and Early Head Start programs, emergency shelters to provide housing assistance and transitional housing and domestic violence programs.

Fenway Health – working to make life healthier, since 1971, for members of the Lesbian, Gay, Bisexual, and Transgender (“LGBT”) community, people living with HIV/AIDS and the broader population. In furtherance of its mission, Fenway Health launched The Fenway Institute, an interdisciplinary center for research, training, education and policy development focusing on national and international health issues, especially related to LGBT communities. As a nationally recognized expert in addressing disparities faced by the LGBT community, Fenway Health is uniquely positioned to mobilize and engage the LGBT cohort regarding needs and priorities.

Charles River Community Health⁵ – providing outpatient health services for a vulnerable and underserved population in the Allston/Brighton and Waltham communities. Charles River Community Health services many undocumented immigrants who face extreme barriers to safety, food access, housing and care. Nearly half of its patients remain uninsured. Stories shared by Charles River Community Health patients and members of its community about the barriers to health and human services they face spurred BIDMC to adopt its Welcome Statement which clearly states that all are welcome to receive care at BIDMC⁶.

Bowdoin Street Health Center – representing one of the most underserved neighborhoods in Boston, Bowdoin Street Health Center has been a trusted cornerstone in the Bowdoin-Geneva

⁴ The Dimock Center was originally known as the New England Hospital for Women and Children.

⁵ Charles River Community Health was originally known as the Joseph M. Smith Community Health Center.

⁶ <https://www.bidmc.org/about-bidmc/mission-and-leadership>

community. As a member of the BGA, described previously in our response to Item 2, Bowdoin Street Health Center recognizes that in order to be effective at providing clinical care to their patients, the health center needs to alleviate barriers to accessing health care by responding to the non-health concerns of members of the vulnerable communities. Bowdoin Street Health Center directly responded to residents' requests for safe space to congregate and exercise, by building a Wellness Center and healthier food options by partnering with neighbors to run a farmer's market. In the past, Bowdoin Street Health Center has participated in community efforts to clean up trash, revitalize abandoned lots, and remove abandoned cars from the area in response to safety concerns. As noted above, Bowdoin Street Health Center also collaborates with 10 other organizations as part of the BGA.

These health centers, as well as the other members of our NIB-CAC, including community-based organizations and partners, will assist with engaging members of the community to identify needs, strategies and priorities of the targeted underserved communities and cohorts during the NIB DoN CHI process. The NIB-CAC will determine the CHI priorities and the categorical allocation of funds, with a particular emphasis on the upstream influencers of health and health equity factors related to social determinants of health, cancer, diabetes, heart disease, housing, and behavioral health. The NIB-CAC will also be responsible for determining the specific under-represented cohorts on which BIDMC will focus and the strategies/efforts that will be used. In addition to the health centers and their community partners and residents, BIDMC also has relationships with numerous community based organizations and initiatives to assist with engaging community residents and priority cohorts.⁷

Provide explicit description of how barriers to engagement are and will be addressed.

As discussed in BIDMC's Community Engagement Plan, BIDMC will address barriers to participation to the community engagement process by working with The Collaborative and the NIB-CAC. BIDMC will be seeking recommendations from The Collaborative and the NIB-CAC for other ways to address barriers to participation and reach a wider audience. The list below outlines strategies and approaches that BIDMC has used in the past. This list will be reviewed and finalized by the NIB-CAC, like the NIB-CAC Charter, and the suggestions are pending input from The Collaborative and final approval from the NIB-CAC:

- Food and drinks – BIDMC will provide dinner, breakfast, snacks, as appropriate, for attendees of community engagement meetings;

⁷ For additional information describing these programs and their impacts, please refer to the Community Benefits 2017 Attorney General Report. Community Benefits Attorney General Report, BIDMC (2017), *available at* <https://www.bidmc.org/-/media/files/beth-israel-org/about-bidmc/helping-our-community/community-initiatives/community-benefits/community-benefits-2017-attorney-general-report.ashx?la=en&hash=4CDBEF3185760C54F2AADD4616366528ACD04372>.

- Meeting locations – BIDMC will hold community engagement meetings in the community, accessible by public transportation and, when possible, free parking will be provided. As noted previously, meetings and primary data collection will ideally occur during existing meetings and gatherings when possible. BIDMC is open to working with the NIB-CAC, DPH and The Collaborative to determine if CHI funds can be used to build a primary data collection and engagement and capacity development training program in the community, to create a CHNA process that is conducted by the community, for the community and creates opportunities for key voices to be heard and engaged;
- Interpreters – BIDMC has budgeted within its 2% administration fee for translation of flyers and materials in different languages and has allotted dollars for up to three (3) interpreters for up to five (5) forums;
- Childcare – BIDMC will make child-friendly activities, such as coloring books and puzzles, available to accommodate parents who bring their children; and
- Compensation – BIDMC has budgeted within its 2% administration fee to offer attendees a limited number of gift cards to local businesses, such as supermarkets, as a token of appreciation for their participation in up to five (5) NIB community forums.

Additional strategies that BIDMC may use to address barriers to participation are set forth in Exhibit D.

NIB-CAC meetings will be open to the public and will be held in the evening at BIDMC to accommodate attendees who work during the day. Moreover, as a commitment to maintaining a transparent process, all agendas, minutes and attendance will be posted on-line and anyone wishing more information about the CHI process can register to receive regular updates. There will be a public comment period at the NIB-CAC meetings, and BIDMC encourages in-person attendance or written comments, and general engagement. BIDMC supports social capital and capacity progress in the community by promoting diverse representation on the NIB-CAC. Current NIB-CAC membership is representative of individuals from various backgrounds, including patients, residents of underserved communities, and individuals within our target cohorts, including older adults.

Describe the evaluation of engagement process.

To ensure that our community engagement efforts demonstrate efficacy and continuous improvement, BIDMC is requesting the use of 10% of CHI funds, equal to \$2,967,804, for evaluation purposes (see proposed CHI budget, attached as Exhibit C). BIDMC will conduct a competitive Request for Proposal (RFP)⁸ process to find a suitable independent evaluator to work with BIDMC to evaluate the planning

⁸ The RFP for the evaluator will include language encouraging subcontracts with local minority or women-owned organizations to develop their capacity within BIDMC's CBSA.

process, engagement outcome, partner perception and experience, and the impact of CHI funding. The independent evaluator will be responsible for designing, implementing, and overseeing the evaluation of BIDMC's CHI process to assess the inclusion of:

- appropriate program content that will be consistent with and satisfy all DPH DoN requirements as well as to guidelines as set by BIDMC;
- appropriate distribution and use of funds that will be consistent with BIDMC CHNA and Implementation Strategy and the NIB Allocation Committee⁹ funding strategy, and;
- effective and transparent opportunities for community engagement that will be consistent with the DPH DoN requirements and the CEP.

Elements of the independent evaluation will include review of power sharing, transparency, accommodations, facilitation and representation. The independent evaluator will be required to demonstrate specific expertise in community engagement, as well as relevant and recent experience in the facilitation and technical support to enable capacity building that enhances the level of community engagement. The independent evaluator will be required to describe their experience using specified frameworks and tools with an ability to work collaboratively with NIB-CAC members, community partners and public health agencies. The independent evaluator will conduct rigorous evaluation that will measure engagement outcomes, assess the planning process, inform the CHI RFP process, and determine the impact of the awarded funds.

Item 3.B:

Questions/Comments and Requests for Additional Information from the Committee Review:

Opportunities for engagement:

- ***Based on the submitted forms, the committee noted limited types of engagement employed to reach a diverse set of stakeholders. It would be helpful if you were able to expand the type of stakeholder engagement you employ in the future, for example going to where groups are already meeting and organized around social determinant of health issues. Additionally, the committee noticed a heavy emphasis in the application on the number of forums in the engagement plan. We think the forums can be a great opportunity but please also describe the intentional methods that can***

⁹ As provided within the CEP Supp, BIDMC will establish an Allocation Committee comprised of individuals who do not have a conflict of interest in regard to the CHI funding. The Allocation Committee will oversee a transparent and competitive process for awarding funds for priorities identified through the community engagement process with input from the NIB-CAC. The Allocation Committee will be comprised of BIDMC staff - Community Benefits staff (Director as Chair), Community Relations staff, Social Work staff, a BIDMC Community Benefits Committee member, a CDC member, a resident, and representatives from the City of Boston. Additionally, we will compile a list of subject matter experts to serve as consultants to the Allocation Committee.

be used to improve the quality of engagement at the forums. As an example, within the application documents, it says that BIDMC engaged 67 people for the 2016 CHNA. Is there a purposeful process of identifying and conducting outreach to engaging particular people, groups and populations? As with all of these questions we understand you will want to be using your advisory committee to help determine these processes however it is helpful and important to us for you to note how you are thinking about and approaching these issues in the CE Plan.

- ***The committee also wanted to know more information about what steps are being taken to ensure stakeholders are given opportunities to grow while they support the Applicant's work. Please articulate a stronger structure for advancing committee governance. With the way the forms were completed, the committee found little to no formal decision-making processes outlined. In order to assess the quality of the engagement, it is vital that we understand how decisions are made and likewise for people involved in the process, they too need to know how their opinions/voices impact decisions. Finally, regarding advisory committee structure we note that the Transportation and Planning representative is not necessarily the type of transportation/planning perspective that can understand and influence this important SDoH. The aim of having a multi-sectoral advisory committee is to have people that can influence the SDoH in your geography.***

Item 3.B – BIDMC's Response:

Note: There are several questions and requests embedded in Item 3.B. For clarity, BIDMC has organized its response to this item as answers to individual questions and requests compiled from the item, as listed below.

Is there a purposeful process of identifying and conducting outreach to engaging particular people, groups and populations?

As outlined in our response to Item 1, BIDMC will remain supportive of The Collaborative's pilot efforts while simultaneously respecting the autonomy of both the NIB-CAC and The Collaborative. BIDMC will work with the NIB-CAC to participate in The Collaborative's primary data collection, augmenting with additional tools and strategies as necessary. As described throughout this response, BIDMC is committed to conducting outreach with the vulnerable populations within its CBSA, and to use its NIB-CAC, its evaluation process and its participation with The Collaborative to continuously augment and grow this community engagement process. BIDMC will work with the NIB-CAC to translate information into different languages, make interpreters available as appropriate, and facilitate access to and receipt of information through the public comment period of the NIB-CAC meetings. BIDMC will push information out to those residents and community-based organizations providing contact information through the CHI web-page, and request that information be shared with each organization's clients,

residents, and constituents. As previously noted in Item 3.A, BIDMC believes that an independent facilitator role will assist in engaging diverse-stakeholders in dialogue around social determinants of health and strategies to address them.

As described above in Item 1, there may be potential for BIDMC to use CHI funds to augment and build the community's capacity for primary data collection with the Collaborative, which presents opportunities for leadership development as both a means to engage and achieve the goal of engagement. Expanding on The Boston CHNA CHIP Collaborative, BIDMC hopes to enhance The Collaborative's engagement strategy – whether by using CHI funds to enhance a community-led process, described above in our response to Item 1, or by expanding the breadth of data collection and engagement activities. BIDMC has already shared summary information about The Collaborative's kickoff meeting with the NIB-CAC, inviting them to attend and encouraging them to disseminate information to attract more participants. According to the NIB-CAC Charter, each member is responsible for assisting with recruitment of and communication with hard-to-reach community residents for forums, focus groups, funding opportunities, or other engagement activities.

Please articulate a stronger structure for advancing committee governance.

Expanding upon the timeline provided within the CEP Supp, BIDMC has scheduled an orientation with the NIB-CAC for late October at which time they will review and adopt the proposed NIB-CAC Charter, attached as Exhibit B. BIDMC anticipates that the NIB-CAC would determine their comfort with decisions via consensus, but recommends that there also be a formal process for voting to be available as backup. Every effort will be made to reach consensus and address concerns or compromises to bring the group together, prior to a formal vote being taken. Each non-staff NIB-CAC member would have an equal vote with a simple majority deciding. Any tied votes will be broken by the Director of Community Benefits. As stated previously, NIB-CAC members must disclose potential conflicts of interest. Agendas will be arranged to allow for ample discussion and engagement of the NIB-CAC members, which will be enhanced by an independent facilitator, if CHI funding is approved.

In support of the NIB-CAC's decision making role, the role of the independent facilitator will provide a neutral party to guide conversation during community forums and meetings. The independent facilitator will help to build consensus and promote unbiased decision-making among the NIB-CAC members. Likewise, an independent facilitator will assist in incorporating public comment during the NIB-CAC's prioritization process to ensure a fully transparent community engagement process.

Describe the type of transportation/planning perspective that can understand and influence this important SDoH.

Following our conversation on September 25, 2018 with DPH, BIDMC is working to identify an additional community-based transportation designee.

The current NIB-CAC Transportation designee, Sarah Hamilton, Vice President of Area Planning and Development at MASCO, has over 30 years' experience in planning and urban design, community, development and transportation planning, and implementation and effective advocacy for transportation improvements in and around the Longwood Area. Among her successes include:

- Technical assistance to Mission Hill Neighborhood Housing Services LINK bus in Mission Hill neighborhood of Boston.
- Advocacy for crosstown bus service linking communities near Andrew/UMass/JFK Station to jobs, health care and education in the Longwood Area and Cambridge (CT2 and CT3 bus service secured; secured federal funding for reconstruction of Melnea Cass Boulevard).
- Funding and completion of feasibility studies for expanded platform capacity at Ruggles Station; successful advocacy with community and planning support for Boston's application which secured a \$25 million Federal TIGER grant will expand morning commuter rail service by over 40%. This helps reverse commuters from the inner city in the Ruggles Area (Intersection of Roxbury, Mission Hill and Fenway/Kenmore neighborhoods).
- Working to include bicycle accommodations from the Southwest Corridor path to the Longwood Area, linking Boston's neighborhoods to the Longwood Area.
- Current advocacy efforts include accelerating design and procurement for new Green Line cars to enhance capacity by 50%; advancing new MBTA bus services to Longwood, from Mattapan, Watertown/Allston, an enhanced key bus route service from JFK/UMass/Andrew Area to Cambridge, and evaluation of all scheduled MBTA bus routes to LMA to identify service gaps.

Item 4:

Questions/Comments and Requests for Additional Information from the Committee Review:

- ***The committee recognized the need to institutionalize community engagement and evaluation where possible. The application materials provided little evidence of institutional structures to support the work of the CHNA/CHIP. Please include in the CE Plan how engagement for the DoN-CHI can be an opportunity for institutionalizing***

these types of activities for community health-related activities for BIDMC. For example how will you be working to expand engagement activities and maintain them over time? The Review Committee also identified wanting to know more about the institutional commitment to evaluating the community engagement/advisory committee structure itself (as well as evaluation of strategy implementation). These issues also led the committee to the following questions:

- Please describe in more detail (but be brief) what was done in 2016-2019 to address the SDOHs? How was that evaluated/determined if the approaches were effective/not effective? And what is the institutional commitment, i.e. through community benefits and other non-DoN funded activities, to address these issues?***
- Please note that the request for CHI funds for management, engagement and communication are far outside the norm. DPH does not necessarily disagree with using resources for these purposes however we really need to understand better the institutional commitment so that these types of activities do not go away when DoN-CHI resources are unavailable. Also, we need more detail on the use of proposed funds across all of the requests.***

Item 4 – BIDMC’s Response:

Note: There are several questions and requests embedded in Item 4. For clarity, BIDMC has organized its response to this item as answers to individual questions and requests compiled from the item, as listed below.

How will you be working to expand engagement activities and maintain them over time?

BIDMC has many institutional structures that support the goals of community engagement efforts and health needs assessment, affirming our commitment to these priorities as an institution. As previously mentioned, BIDMC has been committed to building The Collaborative for several years. Similarly, since 2017, BIDMC has participated and provided financial support for the Boston Area Collaboration on the Social Determinants of Health group in their efforts to identify key shared domains, foster best practice opportunities related to resource investment, and engage in dialogue to identify opportunities for advocacy strategies related to policy, and program development. Given BIDMC’s commitment to community engagement and SDOH, as affirmed within the Community Engagement Plan, unrelated to the CHI, BIDMC increased its Community Benefits staff to 3 FTEs on October 1st 2018, to better coordinate community engagement efforts. Additionally, BIDMC will hire 2 FTEs to augment the management of the engagement and CHI processes.

Please describe in more detail (but be brief) what was done in 2016-2019 to address the SDOHs?

BIDMC has a longstanding commitment to addressing social determinants of health, which by its very essence, can only be accomplished through engagement in and with the community. BIDMC Community Benefits programming includes efforts to address social determinants of health that pre-date both the 501(r) requirements and the recent changes to the Attorney General Community Benefit guidelines for non-profit hospitals. Initially, such efforts included addressing food insecurity and access as well as transportation, but have broadened to include physical activity, healthy eating, job readiness and workforce development. About one-quarter (approximately \$3.5M) of BIDMC's Direct Community Benefits Expenditures, excluding charity care, were spent to address social determinants of health.

How was that evaluated/determined if the approaches were effective/not effective?

BIDMC provides a dashboard to BIDMC's Community Benefits Committee with key indicators for each priority area and prepares an annual update to the Implementation Strategy that is submitted, as required, to the Internal Revenue Service. Through this dashboard, BIDMC is able to evaluate and determine the effectiveness of our past approaches and programming. Specifically for social determinants of health, the majority of indicators are process measures. BIDMC anticipates working with the CHI independent evaluator to incorporate outcome measures when assessing the impact of CHI-funded social determinants of health initiatives. Past programs that received funding addressed issues related to violence, public safety, transportation, food access and security, healthy eating and active living, and employment and job training. These program areas are in addition to programming related to chronic disease prevention and management, access to care, and substance use disorders and mental health. BIDMC's commitment to such efforts will continue irrespective of the CHI though the CHI provides valuable resources to further ongoing work on such SDOH upstream root causes.

The core of our implementation strategy, and our Community Benefits program, rests with well-established programs, such as BIDMC's Center for Violence Prevention and Recovery, founded 45-years ago, our Community Resource Specialists, our Cancer Navigators, and our collaboration with five independent and one BIDMC-licensed community health center, dating back to 1968.¹⁰ In 1997, BIDMC's collaboration with the six community health centers was facilitated by the formation of the Community Care Alliance, a partnership of health centers formed to enhance collaborative clinical and administrative programming. BIDMC's ongoing support to each of the above programs may be provided through staffing and/or in-kind support and BIDMC also delegates funds to these and other community organizations. Each

¹⁰ For additional information describing these programs and their impacts, please refer to the Community Benefits 2017 Attorney General Report. Community Benefits Attorney General Report, BIDMC (2017), *available at* <https://www.bidmc.org/-/media/files/beth-israel-org/about-bidmc/helping-our-community/community-initiatives/community-benefits/community-benefits-2017-attorney-general-report.ashx?la=en&hash=4CDBEF3185760C54F2AADD4616366528ACD04372>.

health center receives an annual Outreach grant from BIDMC to help them conduct their own independent outreach to the communities, linking people who face barriers to accessing needed care and services due to race/ethnicity, insurance status, socio-economic status (encompassing transportation, unemployment, income level, housing status and educational attainment), immigration status, gender identity/sexual orientation, language preference, and health disparities. BIDMC continues to support the Community Care Alliance and health center efforts in a variety of ways including jointly applying for grants, building mental health and substance use disorder capacity at the health centers (e.g., Office Based Opioid Treatment or Medication-Assisted Treatment and supporting the Sewall Center¹¹ rebuild), fostering cancer screening and prevention, and grant funding for programs to address social determinants of health (e.g., Healthy Vitals, Train4Change, Health Literacy, Active Living/Healthy Eating, etc.). Additionally, BIDMC's Community Benefits program supports non-health center programs that include significant workforce development/job readiness programming, the Mayor's Cancer Ride and programs for healthy food access, among others.

And what is the institutional commitment, i.e. through community benefits and other non-DoN funded activities, to address these issues?

BIDMC's commitment to community remains strong, and our on-going Community Benefits programs and commitments will continue and, at times, be augmented by new capital expenditure projects. Future DoN projects will carry with them additional CHI opportunities. BIDMC, like other non-profit hospitals and systems, will be planning on-going changes to facilities and services that are subject to other DoNs. Our on-going work with health centers, community organizations, and public health departments will continue. Depending on the nature of the project, these future CHI obligations could be harmonized with the NIB CHI or could engender an independent but perhaps coordinated CHI process.

Please provide additional detail regarding the budget.

See Exhibit C attached for further budget details.

¹¹ The Dr. Lucy Sewall Center for Acute Treatment Services was opened on April 3, 2018. The 40-bed medically monitored detox unit for alcohol and opioid use disorders is located on The Dimock Center's main campus and will increase access to substance use disorder treatment by serving 4,000 men and women annually.

Exhibit A

DPH September 20, 2018 Request for Additional Information Regarding the BIDMC Community Engagement and Community-based Health Initiative (the “Request”)

Full text of document named “BIDMC CHI Review Comment 9-19-18.docx” attached to email from Ben Wood (DPH) to Nancy Kasen (BIDMC) with copies to Halley Reeves (DPH) and Elizabeth Gerlach (BIDMC) sent September 20, 2018 at 11:58 AM:

Dear Nancy,

Sorry for the delay in sending you our comments, questions and request for additional information. Thank you very much for all the work that went into your application materials, we know it was a lot! A review committee that included staff from my office at DPH as well as volunteers from our inter-departmental community engagement workgroup participated in the review (we had 3 members join us for the review of BIDMCs materials). Below is a summary of that review and includes requests for additional information. Most importantly the request will be for a revised Community Engagement Plan with a focus on understanding how to better leverage and integrate the DoN-CHI processes with the COBTH CHNA-CHIP. It is most likely that a revised timeline will need to be submitted to reflect how that process will play out and how your DoN-CHI engagement and strategy selection process works with it. We'll be able to talk this through when we talk next week and remember that our goal in these review processes is to help build capacity and should not be viewed as punitive.

Sincerely, Ben Wood

Questions/Comments and Requests for Additional Information from the Committee Review:

- **Questions about the upcoming 2019 CHNA/CHIP cycle:** The committee was interested in learning more about how BIDMC is thinking about the 2019 CHNA cycle and what from that process could be leveraged to assist with DoN-CHI community engagement? We would like to see these connections made more explicit in the Community Engagement (CE) Plan to the extent that is possible and with current knowledge about engagement processes for the joint COBTH CHNA/CHIP. Please note that the CE Plan becomes a formal reporting tool so the more detail that is included the easier it will be to follow. We also recognize that the advisory committee(s) will and should play a role in community engagement and that it may change as a result of the committee's feedback.
- **Background question regarding the cycles of community health improvement planning:** The committee is interested in understanding more about how/if BIDMC views the cycles of CHNAs as continuous improvement planning processes. We see this as important in understanding how you think about building on past investments/successes to inform how the DoN-CHI decisions will be made/implemented/evaluated. Please briefly describe how the DoN-CHI will fit into a

continuous process that includes how community benefit determinations and programs work.

- As a general comment, a common response from reviewing all the materials concerning community engagement was that **quality of engagement** ought to also be highlighted in the application materials and considered in the process in addition to quantity, i.e. number of activities, people engaged, etc. Describing quality of engagement involves both A) the types of people engaged as well as the B) opportunities for engagement. See “A” and “B” below for detail and direction for responding to this issue.
- B. Committee review comments regarding types of people/organizations that have been/will be engaged

The committee noted a heavy emphasis on the use of community health centers for engagement. The committee members expressed some concern about an over reliance on engaging the leadership at the health centers who have a financial relationship with BIDMC. We certainly believe and understand the importance of working with and through pre-existing relationships and organizations that have connection to the community. However, ideally, people experiencing inequities, i.e. resident level engagement, would be more engaged in the process of determining the issues and solutions to address inequities. Furthermore, the committee noted that they would like to see more explicit description of how barriers to engagement are and will be addressed. In other words, please describe how you intend to make your engagement processes more accessible to a wide audience. Please consider this in your responses to opportunities you see with leveraging and coordinating with the joint CHNA/CHIP.

Likewise, it was unclear who was engaged at which phase of the engagement process (e.g. the CHNA/CHIP cycles). For example, the committee was confused how the Outer Cape Health Center was engaged throughout the process. While the committee understood that it is in the CAC, they didn't seem to be included in the CHIP and therefore the CHI catchment area. Due to possible changes in BIDMCs community benefits service area we think it's important to be explicit and transparent about who is engaged and for what purpose (please remember the CE Plan becomes a public record). Lastly, the committee noted that there doesn't seem to be any evaluation of engagement processes. Please describe in more detail how you are thinking about evaluating community engagement in addition to evaluation of strategy implementation.

B. Opportunities for engagement:

Based on the submitted forms, the committee noted limited types of engagement employed to reach a diverse set of stakeholders. It would be helpful if you were able to expand the type of stakeholder engagement you employ in the future, for example going to where groups are already meeting and organized around social determinant of health issues. Additionally, the committee noticed a heavy emphasis in the application

on the number of forums in the engagement plan. We think the forums can be a great opportunity but please also describe the intentional methods that can be used to improve the quality of engagement at the forums. As an example, within the application documents, it says that BIDMC engaged 67 people for the 2016 CHNA. Is there a purposeful process of identifying and conducting outreach to engaging particular people, groups and populations? As with all of these questions we understand you will want to be using your advisory committee to help determine these processes however it is helpful and important to us for you to note how you are thinking about and approaching these issues in the CE Plan.

The committee also wanted to know more information about what steps are being taken to ensure stakeholders are given opportunities to grow while they support the Applicant's work. Please articulate a stronger structure for advancing committee governance. With the way the forms were completed, the committee found little to no formal decision-making processes outlined. In order to assess the quality of the engagement, it is vital that we understand how decisions are made and likewise for people involved in the process, they too need to know how their opinions/voices impact decisions. Finally, regarding advisory committee structure we note that the Transportation and Planning representative is not necessarily the type of transportation/planning perspective that can understand and influence this important SDoH. The aim of having a multi-sectoral advisory committee is to have people that can influence the SDoH in your geography.

- The committee recognized the need to **institutionalize community engagement and evaluation** where possible. The application materials provided little evidence of institutional structures to support the work of the CHNA/CHIP. Please include in the CE Plan how engagement for the DoN-CHI can be an opportunity for institutionalizing these types of activities for community health-related activities for BIDMC. For example how will you be working to expand engagement activities and maintain them over time? The Review Committee also identified wanting to know more about the institutional commitment to evaluating the community engagement/advisory committee structure itself (as well as evaluation of strategy implementation). These issues also led the committee to the following questions:
 - Please describe in more detail (but be brief) what was done in 2016-2019 to address the SDoHs? How was that evaluated/determined if the approaches were effective/not effective? And what is the institutional commitment, i.e. through community benefits and other non-DoN funded activities, to address these issues?
 - Please note that the request for CHI funds for management, engagement and communication are far outside the norm. DPH does not necessarily disagree with using resources for these purposes however we really need to understand better the institutional commitment so that these types of activities do not go away when DoN-CHI resources are unavailable. Also, we need more detail on the use of proposed funds across all of the requests.

Exhibit B

Proposed Charter for Beth Israel Deaconess New Inpatient Building (NIB) Community-based Health Initiative (CHI) Community Advisory Committee (CAC)

I. Mandate

Through active and engaged participation, the CAC, BIDMC's designated DPH CHI Advisory Committee, shall assist Beth Israel Deaconess Medical Center (BIDMC) in fulfilling Massachusetts Department of Public Health (MADPH) Determination of Need (DoN) requirements for ongoing community engagement and activities related to the Community-based Health Initiative (CHI). Build upon BIDMC's Community Health Needs Assessment (CHNA/CHIP) (in coordination with The Boston CHNA/CHIP Collaborative (The Collaborative")) to identify the most pressing needs. Determine CHI priorities and the categorical allocation of funds. Recommend criteria for consideration by the CHI Allocation Committee¹ in order to maximize sustainable change, evaluate the impact of funds, and achieve the greatest impact on the upstream root causes, including social determinants of health, that influence health and health equity in BIDMC's Community Benefits Service Area (CBSA). Align allocations with other evidence-based collaborative initiatives, as well as BIDMC initiatives related to Community Benefits and/or the Boston Planning and Development Agency's process and associated benefits and mitigation (e.g., Neighborhood Housing and Jobs Trust Funds). Consider and evaluate options for pooled CHI funding and/or other opportunities for working across different health care systems.

II. Membership

CAC members shall include a diverse group of residents or representatives from a broad range of organizations, and with knowledge of and expertise in the service needs of the communities within the CBSA with an emphasis on the needs currently identified by the Beth Israel Deaconess Medical Center Community Health Needs Assessment and its Community Benefits Committee: access to care, behavioral health, chronic disease management and prevention, and social determinants of health and health risk factors. Members shall include one or more individuals from each of the below categories:

1. Housing: Fenway Community Development Corporation Designee
2. Jobs/Education: Jewish Vocational Services Designee

¹BIDMC will establish an Allocation Committee comprised of individuals who do not have a conflict of interest in regard to the CHI funding. The Allocation Committee will be comprised of BIDMC staff - Community Benefits staff (Director as Chair), Community Relations staff, Social Work staff, BIDMC Community Benefits Committee member, a CDC member, a resident, and representatives from the City of Boston. Additionally, BIDMC will compile a list of subject matter experts to serve as consultants to the Allocation Committee.

3. Regional Planning/Transportation: MASCO Designee; community-based Designee
4. Private Sector and Community-based Organization: Mission Hill Main Streets Designee
5. Community Health Center: Five designees – one from each of the following Dimock, Charles River Community Health, South Cove Community Health Center, Fenway Health and Bowdoin Street Health Center
6. Social Services: Sociedad Latina Designee
7. Local Public Health Dept.: Boston Public Health Commission Designee
8. Additional Government Staff (e.g., Elected Official): Local/State Representative Designee
9. Social Service: Louis D. Brown Peace Institute Designee
10. Boston Resident: Current BIDMC Governing Board's Community Benefits Committee member
11. BIDMC Patient Family Advisory Committee member
12. Chelsea Health Department Designee

BIDMC Staff – Ex Officio:

Nancy Kasen, BIDMC Director of Community Benefits (Chair)

Joanne Pokaski, BIDMC Director of Community Relations and Workforce Development

Patricia McMullin, BIDMC Director of Government Relations (Vice Chair)

Lauren Gabovitch and LaShonda Walker-Robinson, Community Resource Specialists, BIDMC Social Work

III. Conduct of Meetings and Voting

Meetings will be held at BIDMC in person.

Meetings will be chaired by BIDMC's Director of Community Benefits. The Vice-Chair will be BIDMC's Director of Government Relations who will chair the meetings if the Chair is unavailable.

Every effort will be made to reach consensus, prior to a vote being taken. A quorum of 75% will need to be present at the time of any vote.

All decisions will be made by motion, seconded, and called for a vote. Each non-staff member will have one vote. Simple majority will carry the vote. In the event of a tie, the Chair, or if

unavailable, the Vice Chair, will break the tie. The affirmative vote of the Chair, or if unavailable, the Vice Chair, is required to amend the CAC Charter.

Key decisions within the CAC's purview will include the following:

- Additional community engagement beyond The Collaborative efforts
- Priorities on which to focus
- Allocation of funds for the priorities and final allocation plans
- Recommendations on sub-divisions within the priorities (either by sub-cohort or type of program), as appropriate
- Adoption and update of the CAC Charter

IV. Member Expectations and Attendance

Each member will:

- Actively participate in all seven monthly two-hour in-person meetings;
- Attend at least 75% of all quarterly in-person meetings (see below);
- Attend all semi-annual in-person meetings (see below);
- Attend any special meetings, as needed;
- Failure to attend the required number of meetings will be grounds for removal;
- Review agendas and materials prior to each meeting;
- Assist in recruiting hard-to-reach cohorts/sub-populations/participants for community forums or other qualitative data collection to help identify those who can benefit most from CHI funds
- Attend at least one community forum or other primary and qualitative data collection efforts;
- Review and adopt a conflict of interest disclosure process;
- In accordance with the CAC's conflict of interest disclosure procedures, disclose any perceived or actual conflict of interest upon (i) joining the CAC related to BIDMC and (ii) on an ongoing basis, related CHI allocation or priorities;
- Recuse oneself from discussion and any votes related to one's conflict of interest; and
- Participate in all evaluation processes, including but not limited to a CAC self-evaluation, as determined by the independent evaluator.

Following DPH's approval of the Allocation Plan, members shall attend at least 75% of four quarterly in-person meetings (1.5 hours per meeting) at BIDMC to obtain information on the status of the CHI process. Members will continue to educate and engage their community/cohort in the CHI process, and advise BIDMC, as needed on decisions related to the Allocation Plan. Following the Allocation Plan, a separate Allocation Committee will determine the actual awards, funding amounts, and grants/grant recipients.

Following the allocation of funding, the NIB-CAC will continue to meet semi-annually for the duration of the CHI. One of the two annual meetings meeting will be a public forum at which grant recipients will present on the progress of their project.

In summary:

Month:	Frequency of Meeting:
1 – 6 or 7	Monthly
7- 18	Quarterly
18 – 72	Semi-annually (includes annual public forum)

The Chair and Vice Chair shall review attendance and augment membership, as needed, to fill vacancies, ensure consistency with MADPH requirements and evolving community needs. The Chair and Vice Chair shall review membership for reappointments and new appointments on a three year cycle.

V. Transparency

The schedule, location, minutes and attendance from all NIB-CAC meetings will be available to the public (posted on the BIDMC NIB Web-site). A draft calendar with sample agendas is included as Attachment A.

Monthly and quarterly meetings will be open to the public.

Members of the public may provide written or oral comments during public comment periods.

Annually, BIDMC will host a forum where grant recipients will present on their projects sharing progress to date.

Attachment A:

Monthly Meetings	Proposed Agenda
October 2018	CAC Orientation; review and adopt the CAC Charter; review BIDMC's prior CHNA/CHIP; explain Boston CHNA/CHIP Collaborative
November 2018	Review purpose of the CHNA/CHIP and DPH priorities; begin discussion of additional community engagement (locations, cohorts, questions)
January 2019	Review proposed plan for CE - discuss marketing, recruitment, and questions
February 2019	Conduct CE - provide update and receive input/feedback
March 2019	Conduct CE - provide update and receive input/feedback
April 2019	Summarize findings of CE and begin prioritization process
May 2019	Finalize prioritization process
June 2019	Review draft funding plan for submission to DPH; discuss dissemination/CE for RFP; via email obtain input/update from NIB-CAC on any additional feedback received from DPH on proposed allocation plan;
Quarterly Meetings	
August or September 2019	Discuss dissemination/CE for RFP; Provide update and continue to engage community re: funding awards, RFP process, etc.
December 2019 – March 2020	Provide update and continue to engage community re: funding awards, process, etc.
Semi-Annual/Annual Meetings:	
December 2020 – June 2026	Alternate with annual meeting at which grantees present on progress

Exhibit C

New Inpatient Building Community Health Initiative Budget

In light of the conversation that BIDMC had with DPH on September 25, 2018, we have reviewed our New Inpatient Building Community Health Initiative Budget and are providing this updated budget proposal ("CHI Budget")¹.

The breakdown of Community Health Initiative (CHI) dollars for the New Inpatient Building is as follows:

Maximum Capital Expenditure (MCE):	\$593,560,750
CHI (5% of MCE):	\$29,678,038
CHI Administrative Fee (2%):	\$593,561
Evaluation (10% of CHI):	\$2,967,804
Subtotal (12% of CHI):	\$3,561,365
Facilitation (0.8% of CHI):	\$250,000
Total (12.8% of CHI):	\$3,811,365

Evaluation Overview:

BIDMC is seeking to use 10% of the CHI (\$2,967,804) for evaluation purposes. BIDMC will undertake a competitive procurement process for an independent evaluator which will be responsible for working with BIDMC to conduct an evaluation of all components of the CHI process including engagement, engagement outcomes, the planning process, the RFP process, and the impact of awarded grants. The evaluation will include definition of CHI metrics, data management, data collection, data reporting, data analysis, and transparent dissemination of lessons learned and best practices. BIDMC will leave open the opportunity for potential opportunities to build evaluation capacity, such as logic models, for grantees and other interested stakeholders.

Administration Fee Overview:

Applicants submitting a Tier 3 CHI are eligible to obtain 2% of the CHI amount for administrative costs. BIDMC is seeking to use the CHI Administrative Fee (\$593,561) for community outreach, development of the RFP, technical assistance, logistical and communication support to ensure widespread information sharing and transparency about priorities and processes and to cover

¹ This updated CHI Budget reflects the adjustment of amounts among budget sub-categories and the corresponding percentages of the Maximum Capital Expenditure (MCE) from those included in the "BIDMC Supplemental Information to the Community Health Initiative Community Engagement Plan Form", Attachment I.2, submitted as part of the Application. Note, the MCE (and the MCE percent calculation for each sub-category amount) have been corrected in this CHI Budget to correspond with the correct MCE amount contained in the Application.

miscellaneous expenses such as parking, media, and food for the NIB-CAC meetings or public forums.

Facilitation Fee Overview:

BIDMC is seeking to use 0.8% of CHI (\$250,000) to ensure transparent and engaged facilitation at approximately 31 meetings, over 8 years, that will be open to the public. The use of an independent facilitator would ensure a non-biased and transparent discussion among participants throughout the BIDMC CHI process. Upon approval of the Facilitation Fee, BIDMC would undertake a competitive RFP process to identify a qualified independent facilitator. Efforts will be made to select a qualified Facilitator from and knowledgeable about Boston and BIDMC's Community Benefits Service Area (CBSA) neighborhoods and/or with the ability to reach into and subcontract within the BIDMC CBSA to underrepresented minority or women-owned co-Facilitator partners.

With this funding, BIDMC will seek to hire an independent facilitator skilled and experienced with facilitating complex planning processes involving varying levels of sophistication from large organizations to grass roots community nonprofits, community residents, diverse sectors within the community, and other CHI processes. The independent facilitator will be knowledgeable and versed in theories and methods of community engagement and negotiation and will have expertise in bringing together different sectors of the community beyond health care such as education, housing, public health, social services, private sector, and other community-based organizations, as well as individual residents and community stakeholders.

Exhibit D

Strategies to Address Barriers to Participation	
Barrier to Participation	Strategies
Communication	<p>Spoken/Written Languages: BIDMC has and will continue to provide interpreters to accommodate prevalent languages in the CBSA - Haitian Creole, Spanish, Cape Verde, and Chinese</p> <p>Literacy level: All written communication will be reviewed by a literacy specialist for literacy level – with the goal of keeping materials at the lowest literacy level possible.</p>
Location	<p>Work with the NIB-CAC and our community based organizations/partners to hold all forums near Public Transportation and/or with ample parking;</p> <p>Public meetings could be held at community-based organizations, community centers, health centers, etc.</p>
Time	<p>Public Meetings will be held at times convenient for working families - evenings or weekends; we will work with our partners to determine if there are existing meetings at which we can join (i.e., after work in order for working adults to attend</p>
Childcare	<p>BIDMC will provide quiet activities (coloring books, crayons, puzzles, etc.) to occupy children who accompany their parents.</p>
Food and Stipends	<p>BIDMC will provide food and drink for the meeting and \$25/stipends for participants</p>

ATTACHMENT 3



Massachusetts Department of Public Health Determination of Need Community Health Initiative Community Engagement Plan

Version: 8-1-2017

The Community Engagement Plan is intended for those Applicants with CHIs that require further engagement above and beyond the regular and routine CHNA/CHIP processes. For further guidance, please see the *Community Engagement Standards for Community Health Planning Guidelines* and its appendices for clarification around any of the following terms and questions.

All questions in the form, unless otherwise stated, must be completed.

Approximate DoN Application Date: 07/27/2018 DoN Application Type: Hospital/Clinic Substantial Capital Expenditure

Applicant Name: CareGroup, Inc.

What CHI Tier is the project? ☐ Tier 1 ☐ Tier 2 ☒ Tier 3

1. Community Engagement Contact Person

Contact Person: Nancy Kasen Title: Director, Community Benefits

Mailing Address: Beth Israel Deaconess Medical Center, 109 Brookline Avenue, BR 270

City: Boston State: Massachusetts Zip Code: 02215

Phone: 6176672602 Ext: E-mail: nikasen@bidmc.harvard.edu

2. Name of CHI Engagement Process

Please indicate what community engagement process (e.g. the name DoN CHI Initiative associated with the CHI amount) the following form relates to. This will be used as a point of reference for the following questions.

(please limit the name to the following field length as this will be used throughout this form):

BIDMC New Inpatient Building

3. CHI Engagement Process Overview and Synergies with Broader CHNA /CHIP

Please briefly describe your overall plans for the CHI engagement process and specific how this effort that will build off of the CHNA / CHIP community engagement process as is stated in the *DoN Community-Based Health Initiative Planning Guideline*.

Beth Israel Deaconess Medical Center (BIDMC) maintains a steadfast and long-standing commitment to the health and well-being of our community. BIDMC founded and supports the Community Care Alliance (CCA), a health center network that includes five Boston health centers (Bowdoin Street Health Center, Charles River Community Health, The Dimock Center, Fenway Health, and South Cove Community Health Center) serving over 100,000 low-resource, diverse patients annually. Since first partnering with The Dimock Center in 1968, and Fenway Health in 1974, Beth Israel and the Deaconess hospitals, respectively, have supported collaborative and/or delegated community-based health programming for decades. BIDMC continues this legacy with robust Community Benefits programming to address social determinants of health, health risk factors and other barriers to optimizing health and well-being. This DON/CHI will be no exception.

The CHI engagement will build upon on secondary and primary data collection and community engagement that occurred during BIDMC's FY 16 community health needs assessment (CHNA) in five neighborhoods - one in each of BIDMC's community benefit service area (CBSA) neighborhoods (Bowdoin/Geneva, Allston/Brighton, Fenway/Kenmore, Chinatown and Roxbury). BIDMC's CHNA priority cohorts include older adults, racially/ethnically/linguistically diverse populations, low-resources individuals and those who identify as lesbian, gay, bisexual or transgender. The FY 16 CHNA community engagement included broad community and public health participation and extensive engagement including key informant interviews, public/community forums and oversight by a diverse and knowledgeable Community Benefits Committee, a sub-committee of BIDMC's Board of Directors. [see Appendix for list of key informant interviews and forums].

Using input from BIDMC's New Inpatient Building (NIB) Community Advisory Committee, BIDMC will conduct up to five community forums focused on the neighborhoods and/or specific cohorts or needs highlighted in BIDMC's FY 16 CHNA and CBSA. Community forums will be facilitated by an independent facilitator to ensure engaged participation to help make sure BIDMC pursues a community-engaged strategy for the selected CHI priority/ies.

4. CHI Advisory Committee

In the CHNA/CHIP Self Assessment, you listed (or will list) the community partners that will be involved in the CHI Advisory Committee to guide the BIDMC New Inpatient Building . As a reminder:

For Tier 2 DON CHI Applicants: The CHI Advisory Committee is tasked with helping select DoN Health Priorities based on the CHNA / CHIP unless the Applicant is directed by DPH to conduct additional community engagement. If so, the advisory committee's role is to guide that additional work.

For Tier 3 DON CHI Applicants: The CHI Advisory Committee is to select DoN Health Priorities based on, **but not exclusive to**, the CHNA / CHIP. This includes the additional community engagement that must occur to develop the issue priorities.

5. Focus Communities for CHI Engagement

Within the BIDMC New Inpatient Building , please specify the target community(ies), please consider the community(ies) represented in the CHNA / CHIP processes where the Applicant is involved.

Add/Del Rows	Municipality	If engagement occurs in specific neighborhoods, please list those specific neighborhoods:
<input checked="" type="checkbox"/> <input type="checkbox"/>	Boston	Specific neighborhoods include Bowdoin Geneva, Roxbury, Fenway/Kenmore, Chinatown and Allston/Brighton

6. Reducing Barriers

Identify the resources needed to reduce participation barriers (e.g., translation, interpreters, child care, transportation, stipend). For more information on participation barriers that could exist, please see Appendix A from the *Community Engagement Standards for Community Health Planning Guidelines* <http://www.mass.gov/eohhs/docs/dph/quality/don/guidelines-community-engagement.pdf>

As with prior community engagement and community forums, BIDMC will hold the forums in locations, preferably in the community, that are accessible, near/reachable via public transportation and also offer parking (complimentary). BIDMC will provide food and interpretation. We will also provide quiet activities (coloring books, crayons, puzzles, etc.) to occupy children who accompany their parents.

7. Communication

Identify the communication channels that will be used to increase awareness of this project or activity:

BIDMC will post all forums and updates on the BIDMC New Inpatient Building web-site. The web-site will allow individuals to register to receive notices of upcoming events, meetings, etc. NIB CHI page will also contain BIDMC NIB-CAC minutes, attendance and meeting dates/times. Meetings will be open to the public, with time reserved for written or oral public input.

Additionally, BIDMC will advertise community forums via flyers (in prevalent languages) distributed to community-based organizations, community partners and others identified by the BIDMC NIB CAC.

8. Build Leadership Capacity

Are there opportunities with this project or activity to build community leadership capacity?

☒ Yes ☐ No

If yes, please describe how.

Working with the BIDMC NIB CAC, depending on priorities selected, BIDMC is open to exploring opportunities to foster community leadership.

9. Evaluation

Identify the mechanisms that will be used to evaluate the planning process, engagement outcome, and partner perception and experience:

BIDMC will hire an independent evaluator through a competitive request for proposal process. Effort will be made to select a qualified evaluator from and/or knowledgeable about Boston and BIDMC's CBSA neighborhoods and cohorts. The evaluator will conduct rigorous evaluation that will measure engagement outcomes, assess the planning process, inform the CHI RFP process, and determine the impact of the awarded funds. BIDMC anticipates that the evaluation will occur over the full length of the CHI.

10. Reporting

Identify the mechanisms that will be used for reporting the outcomes of this project or activity to different groups within the community:

Residents of Color

BIDMC NIB Annual Public Meeting in collaboration with the NIB BIDMC Community Advisory Committee; on-going update via the CHI page on the BIDMC NIB web-site; updates/highlights shared in the community by members of the NIB BIDMC Community Advisory Committee; NIB BIDMC Community Advisory Committee meetings will be open to the public

Residents who speak a primary language other than English

Availability of interpreters at the community forums, the BIDMC NIB Annual Public Meeting and BIDMC NIB Community Advisory Committee meetings; annual updates translated into languages determined by BIDMC and the NIB BIDMC Community Advisory Committee

Aging population

BIDMC NIB Annual Public Meeting in collaboration with the NIB BIDMC Community Advisory Committee; on-going update via the CHI page on the BIDMC NIB web-site; updates/highlights shared in the community by members of the NIB BIDMC Community Advisory Committee; NIB BIDMC Community Advisory Committee meetings will be open to the public

Youth

BIDMC NIB Annual Public Meeting in collaboration with the NIB BIDMC Community Advisory Committee; on-going update via the CHI page on the BIDMC NIB web-site; updates/highlights shared in the community by members of the NIB BIDMC Community Advisory Committee; NIB BIDMC Community Advisory Committee meetings will be open to the public

Residents Living with Disabilities

BIDMC NIB Annual Public Meeting in collaboration with the NIB BIDMC Community Advisory Committee; on-going update via the CHI page on the BIDMC NIB web-site; updates/highlights shared in the community by members of the NIB BIDMC Community Advisory Committee; NIB BIDMC Community Advisory Committee meetings will be open to the public

GLBTQ Community

BIDMC NIB Annual Public Meeting in collaboration with the NIB BIDMC Community Advisory Committee; on-going update via

the CHI page on the BIDMC NIB web-site; updates/highlights shared in the community by members of the NIB BIDMC Community Advisory Committee; NIB BIDMC Community Advisory Committee meetings will be open to the public

Residents with Low Incomes

BIDMC NIB Annual Public Meeting in collaboration with the NIB BIDMC Community Advisory Committee; on-going update via the CHI page on the BIDMC NIB web-site; updates/highlights shared in the community by members of the NIB BIDMC Community Advisory Committee; NIB BIDMC Community Advisory Committee meetings will be open to the public

Other Residents

BIDMC NIB Annual Public Meeting in collaboration with the NIB BIDMC Community Advisory Committee; on-going update via the CHI page on the BIDMC NIB web-site; updates/highlights shared in the community by members of the NIB BIDMC Community Advisory Committee; NIB BIDMC Community Advisory Committee meetings will be open to the public

11. Engaging the Community At Large

Which of the stages of a CHNA/CHIP process will the BIDMC New Inpatient Building focus on? Please describe specific activities within each stage and what level the community will be engaged during the BIDMC New Inpatient Building . While the step(s) you focus on are dependent upon your specific community engagement needs as a result of your previous CHNA/CHIP work, for tier 3 applicants the CHI community engagement process must at a minimum include the "Focus on What's Important," "Choose Effective Policies and Programs" and "Act on What's Important" stages. (For definitions of each step, please see pages 12-14 in the *Community Engagement Standards for Community Health Planning Guidelines* <http://www.mass.gov/eohhs/docs/dph/quality/don/guidelines-community-engagement.pdf>).

	Inform	Consult	Involve	Collaborate	Delegate	Community - Driven / -Led
<input checked="" type="checkbox"/> Assess Needs and Resources	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	Inform	Consult	Involve	Collaborate	Delegate	Community - Driven / -Led
Please describe the engagement process employed during the "Assess Needs and Resources" phase.	<p>The BIDMC Patient Family Advisory Council (PFAC) is engaged in and participates on the New Inpatient Building planning committee as well as user group panels. PFAC input is being incorporated into the New Inpatient Building design process and the decision for single-bedded rooms was informed by a 2016 survey conducted by the PFAC, which indicated that privacy is especially important to address several patient panel needs. Similarly, the Universal Access ADA Staff and Advisory Council have been involved in the planning for the new building. As BIDMC serves a large deaf/hard-of-hearing and Limited English Proficient patient population, BIDMC's Interpreter Services department has been involved in the technology visioning Shari Gold Gomez has been included in the technology visioning processes, aiming to leverage technology in the design of the NIB to best meet the needs of these patients.</p> <p>In addition to the engaging the PFAC, BIDMC is committed to open, transparent communication and collaboration with community groups, neighbors, state and local officials and agencies, and neighboring institutions. As such, BIDMC met with the Roxbury Tenants of Harvard, MASCO, and the Longwood Medical Area Taskforce to discuss the design of the building and understand neighborhood concerns. Related to concerns expressed, BIDMC is working to conduct a noise study, options for ensuring that the building is bird-friendly and does not adversely impact the Riverway.</p> <p>BIDMC has also consulted with the CEO's of the Community Care Alliance, the five Boston health centers - Bowdoin Street Health Center, Charles River Community Health, The Dimock Center, Fenway Health and South Cove Community Health Center - on the plans for the NIB. The health centers raised concerns about signage during construction, particularly for limited English proficient patients. BIDMC is working with the health centers to address this issue.</p> <p>BIDMC also consulted with its Community Benefits Committee.</p>					
<input checked="" type="checkbox"/> Focus on What's Important	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
Please describe the engagement process employed during the "Focus on What's Important" phase.	<p>BIDMC will establish diverse stakeholder group to guide identification and prioritization of expanded health priority selection. BIDMC anticipates conducting five community forums – determined with input from BIDMC NIB-CAC (see below). BIDMC will reduce barriers to participation by providing food, interpretation, parking and/or selecting locations that are T-accessible. All NIB-CAC and community forums will be facilitated by an independent facilitator that BIDMC will hire.</p> <p>BIDMC will create an advisory committee (NIB-CAC) that represents a broad range of organizations to meet Massachusetts Department of Public Health (DPH) Determination of Need (DON) requirements while also meeting BIDMC's Community Health Needs Assessment (CHNA) identified priority areas: access to care, behavioral health, chronic disease management and prevention, and social determinants of health and health risk factors. The identified members have knowledge of and expertise in the service needs of the community/City with an emphasis on the identified priority areas.</p> <p>Please refer to Supplemental Information for the CHI/Community Engagement Form for additional information.</p>					
<input checked="" type="checkbox"/> Choose Effective Policies and Programs	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	Inform	Consult	Involve	Collaborate	Delegate	Community - Driven / -Led
Please describe the engagement process employed during the "Choose Effective Policies and Programs" phase.	<p>BIDMC NIB-CAC Transparency</p> <p>The schedule, location, minutes and attendance from all NIB-AC meetings will be posted on the BIDMC NIB Web-site. Monthly and quarterly meetings will be open to the public and members of the public may provide written or oral comments during public comment periods. Annually, BIDMC will host a forum where grant recipients will present on their projects sharing progress to date.</p> <p>Subsequent to submitting and receiving approval from the DPH on the Allocation Plan, BIDMC will issue a request for proposals for funding opportunities based on the priorities established through the NIB-CAC process. BIDMC anticipates offering two RFP cycles. Please refer to Supplemental Information for the CHI/Community Engagement Form for additional information.</p>					
<input checked="" type="checkbox"/> Act on What's Important	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Please describe the engagement process employed during the "Act on What's Important" phase.	<p>BIDMC will administer a transparent and widely publicized request for proposal process based on priorities and strategies identified with input from the BIDMC NIB CAC. BIDMC expect to offer multi-year grants but will explore "seed" grants or technical assistance options to build the evaluation and infrastructure capacity of prospective applicants and/or grant recipients. All grants will be overseen by BIDMC staff and will be included in and/or subject to the evaluation process and metrics. Likewise, grantees will share/present at the annual public meetings.</p>					
<input checked="" type="checkbox"/> Evaluate Actions	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Please describe the engagement process employed during the "Evaluate Actions" phase.	<p>BIDMC will hire an independent evaluator to conduct independent and rigorous evaluation. The evaluation will measure engagement outcomes assess the planning process, be used to inform the RFP process(es), and determine impact of awarded grants.</p> <p>Please refer to Supplemental Information for the CHI/Community Engagement Form for additional information.</p>					

12. Document Ready for Filing

When the document is complete, click on "document is ready to file". This will lock in the responses, and Date/Time stamp the form. To make changes to the document, un-check the "document is ready to file" box. Edit the document, then lock file and submit. Keep a copy for your records. Click on the "Save" button at the bottom of the page.

To submit the application electronically, click on the "E-mail submission to DPH" button.

This document is ready to file: ☒

Date/Time Stamp: 07/27/2018 12:47 pm

E-mail submission to DPH

Attachments to the Application
Attachment I.2

**BIDMC Supplemental Information to the
Community Health Initiative Community Engagement Plan Form**

This narrative is to supplement information contained in the *Community Health Initiative Community Engagement Plan Form*.

As outlined in the Community Engagement Form, BIDMC proposes a community engagement process that adheres to the specifications in the Department's *Community Engagement Standards for Community Health Planning Guidelines*. BIDMC met with the Director and staff of the Department's Office of Community Health Planning and Engagement to review and discuss the proposed engagement process. (Refer to Appendix A.)

Community Engagement for the Community Health Initiative ("CHI") encompasses additional activity required by the Determination of Need ("DoN") process that will build upon BIDMC's most recent Community Health Needs Assessment ("CHNA") (See Supplemental Information on Community Health Needs Assessment). This effort will begin with the appointment of the BIDMC New Inpatient Building ("NIB") Community Advisory Committee ("NIB-CAC").

I. New Inpatient Building Community Advisory Committee:

The NIB-CAC will advise and assist BIDMC on the community engagement process for the New Inpatient Building, supplementing BIDMC's community engagement, CHNA and existing programming. The NIB-CAC will provide recommendations to BIDMC's NIB Allocation Committee ("NIB-ALLC") on CHI priorities and categorical allocation of funds in order to best support the community. NIB-CAC efforts will align with and/or be informed by BIDMC initiatives related to the Boston Planning and Development Agency's process and associated benefits and mitigation, such as Neighborhood Housing and Jobs Trust Funds.

Upon receipt of approval of the NIB Determination of Need, the NIB-CAC will begin meeting. Timelines and agendas for NIB-CAC meetings are proposed as follows:

Proposed Initial 6-months Timeline

NIB-CAC members will attend six monthly two-hour in-person meetings, reviewing agendas and materials prior to each meeting. Meetings will commence immediately following award of DoN approval and will be held at BIDMC. Members will assist BIDMC with framing and engaging the community for community forums by brainstorming relevant topics, drafting a list of questions, and proposing meeting locations/publicizing and assisting with recruitment for these forums. Members will also attend at least one community forum.

Proposed Initial 6-months Agendas

Month 1: Review purpose of the CHNA/CHIP and DPH priorities; begin discussion of additional community engagement (locations, cohorts, questions)

Month 2: Review proposed plan for CE - discuss marketing, recruitment, and questions

Month 3: Conduct CE - provide update and receive input/feedback

Month 4: Conduct CE - provide update and receive input/feedback

Attachments to the Application
Attachment I.2

Month 5: Summarize findings of CE and begin prioritization process

Month 6: Finalize prioritization process; Review draft funding plan for submission to DPH; discuss dissemination/CE for RFP; via email obtain input/update from NIB-CAC on any additional feedback received from DPH on proposed allocation plan; note - following submission of the Allocation Plan to DPH, NIB-CAC members may be required to attend a seventh meeting to advise on changes, if necessary.

Proposed Post-Initial 6-month Timeline (Quarterly - through March 2020):

Subsequent to the DPH's approval of the Allocation Plan, members will attend four quarterly in-person meetings (1.5 hours) at BIDMC to obtain information on the CHI process and continue to educate and engage their community/cohort in the CHI process. During the meetings, the NIB-CAC will discuss dissemination of community engagement for requests for proposals ("RFP") and provide updates on continued engagement of the community, such as funding awards and the RFP process. The NIB-CAC will continue to meet semi-annually for the duration of the CHI, of which one meeting will be a public forum at which grant recipients will present on the progress of their project.

In summary:

Month:	Frequency of Meeting:
1 – 6 or 7	Monthly
7- 18	Quarterly
18 – 72	Semi-annually (includes annual public forum)

BIDMC will hire, through a competitive RFP process, an independent facilitator to facilitate all NIB-CAC meetings, annual forums and community forums. BIDMC is seeking to use 2% (\$469,625) of all CHI funding (\$26,718,412) to ensure transparent and engaged facilitation at approximately 27 meetings (over 8 years) that will be open to the public.

II. CHI Timing

Given the breath and scope of the CHI and the desire to maximize the impact of the CHI fund, BIDMC requests an extension of six months to enable an engaged, meaningful, and transparent RFP process. BIDMC proposes to place initial funding amounts, within 12 months of notice of approval, in escrow and undertake a competitive RFP process to be completed 18 months from notice of approval.

BIDMC expects to offer two sequential RFP cycles and anticipates awarding multi-year grants. This will allow the second cycle to incorporate lessons learned and best practices obtained during the first cycle. Thus, BIDMC requests additional time to carry out the total disbursement of funds for the CHI. BIDMC requests an eight year period to maximize the impact of the awarded funds.

III. Allocation Committee

BIDMC will establish an Allocation Committee comprised of individuals who do not have a conflict of interest in regard to the CHI funding. The Allocation Committee will oversee a transparent and

Attachments to the Application
Attachment I.2

competitive process for awarding funds for priorities identified through the community engagement process with input from the NIB-CAC.

The Allocation Committee will be comprised of BIDMC staff - Community Benefits staff (Director as Chair), Community Relations staff, Social Work staff, BIDMC Community Benefits Committee members, a CDC member, a resident, and representatives from the City of Boston. Additionally, we will compile a list of subject matter experts to serve as consultants to the Allocation Committee.

As stated above, BIDMC anticipates offering multi-year grants with two RFP cycles. BIDMC requests to use 3% of all CHI funds (\$875,000) for administering the transparent RFP process, technical assistance to grantees, tracking and monitoring progress of grants, and overall coordination of grant awards.

IV. Logistics and Communication:

BIDMC was founded to serve the underserved and, as such, is rooted in community. Therefore, it proposes engaging in an on-going dialogue with the community and an annual meeting at an accessible location that will be professionally facilitated and will provide updates on the status of our DON and CHI. The BIDMC communication plan includes:

- a. A regularly updated web-site hosted by BIDMC,
- b. Pushed email updates (collecting participants' contact information during Community Engagement) and
- c. An annual forum, independently/professionally facilitated, at which grant recipients will share progress (including CHI fund recipients presentations, Q&A, etc.) on the CHI.

BIDMC requests to use 2% (\$510,000) for CHI logistical and communication support to ensure widespread information sharing and transparency about priorities and processes; and to cover miscellaneous expenses such as parking for the NIB-CAC or the public forums, AV, food, etc.

V. Evaluation:

BIDMC will undertake a competitive bidding process for an independent evaluator which will be responsible for evaluating all components of the CHI process including engagement outcomes, the planning process, the RFP process, and the impact of awarded grants. BIDMC is seeking to use 6% (\$1.6M) for evaluation.