

Community Benefits Report

Fiscal Year 2021

Beth Israel Lahey Health 
Beverly Hospital

Beth Israel Lahey Health 
Addison Gilbert Hospital

SECTION I: SUMMARY AND MISSION STATEMENT

Summary and Mission Statement:

Northeast Hospital Corporation (NHC), also known as Beverly and Addison Gilbert Hospitals (BH/AGH) and Bayridge Hospital, is a member of Beth Israel Lahey Health (BILH). NHC consists of multiple entities organized to service the needs of those in its communities. NHC, under a single license, operates Beverly Hospital, Addison Gilbert Hospital, and Bayridge Hospital, as well as an outpatient facility, Lahey Outpatient Center Danvers. All are members of BILH. BILH was established with an appreciation for the importance of caring for patients and communities in new and better ways. At the heart of BILH is the belief that everyone deserves high-quality, affordable health care, close to home. This belief is what drives us to work with community partners across the region to promote health, expand access, and deliver the best care in the communities BILH serves. BILH's Community Benefits staff is committed to working collaboratively with BILH's communities to address the leading health issues and create a healthy future for individuals, families, and communities.

Beverly and Addison Gilbert Hospitals' Community Benefits Mission Statement: The Community Benefits Program at BH/AGH partners with community leaders and organizations to assess and meet the health care needs of the community. Strategies used in community benefits health activities include prevention, early detection, early intervention, long-term management, and collaborative efforts with the affiliated organizations that make up the BILH system. Health issues addressed encompass safety, chronic disease, infectious disease, substance abuse, mental health, maternal and child health, and elder health.

The following annual report provides specific details on how NHC is honoring its commitment and includes information on the hospitals' Community Benefits Service Area (CBSA), community health priorities, target populations, and community partners as well as detailed descriptions of its Community Benefits programs and their impacts. More broadly, our mission is fulfilled by:

- **Involving BH/AGH staff**, leadership, and dozens of community partners in the community health assessment process as well as in the development, implementation, and oversight of the Implementation Strategy.
- **Engaging and learning from residents** throughout the service area, in all aspects of the community benefits process, including assessment, planning, implementation, and evaluation. In this regard, special attention is given to engaging diverse perspectives from those who are not patients of BH/AGH and those who are often left out of the assessment, planning, and program implementation processes.
- **Assessing unmet community need** by collecting primary and secondary data (both quantitative and qualitative) to identify unmet health-related needs and to characterize those in the community who are most vulnerable and face disparities in access and outcomes.
- **Implementing community health programs and services** in the hospitals' CBSA geared toward improving the current and future health status of individuals, families, and communities by removing barriers to care, addressing social determinants of health, strengthening the health care system, and working to decrease the burdens of the leading health issues.
- **Promoting health equity** by addressing social and institutional inequities, racism, and bigotry, as well as ensuring that all patients are welcomed and received with respect and cultural responsiveness.
- **Facilitating collaboration and partnership** within and across sectors (e.g., public health, health care, social services, business, academic, and community health) to advocate for, support, and implement effective health policies, community programs, and services.

Target Populations:

BH/AGH's CBSA includes the towns of Ipswich, Essex, Gloucester, Rockport, Manchester-by-the-Sea, Beverly, Danvers, Middleton, and Lynn. Given that BH/AGH operates multiple buildings under a single state license and serves different geographic areas and populations, the communities that are part of the CBSA are an aggregate of these areas and populations. As new collaborations and partnerships develop, BH/AGH will focus its efforts in other CBSA communities to ensure they have the greatest impact. The CBSA does not exclude medically underserved, low-income, or minority populations. BH/AGH is committed to promoting health and well-being, addressing health disparities, and working to achieve health equity.

Key Accomplishments for Reporting Year:

The accomplishments highlighted in this report are based on priorities identified and programs contained in BH/AGH's FY19 Community Health Needs Assessment (CHNA) and FY20-22 Implementation Strategy (IS):

- ***Community Home Blood Draw Program*** – BH/AGH staff provided home blood draws for 5,761 patients who were homebound due to illness, injury, or transportation issues.
- ***Compass Moms Do Care Program*** – In FY21 provided support for more than 40 pregnant and parenting women with a history of substance use. The COVID-19 pandemic led to suspension of in-person groups and services. As a result, the program supported women through virtual programming.
- ***Breast Cancer Risk Assessment*** – In FY21, BH/AGH provided 3,089 free breast Cancer Risk Assessment (CRA) screenings to identify persons who may have a higher lifetime risk of developing breast cancer, and provided follow-up with all participants' physicians.
- ***Patient Financial Counseling*** - In FY21, BH/AGH continued to meet the health care needs of patients and assisted 67,500 patients, a 13.5 % increase over FY20. Patients served included those with existing Medicaid, patients who presented as self-pay and completed an application with a Financial Navigator, and patients who qualified for upgraded MassHealth coverage.
- ***Beverly Bootstraps*** – Supported Beverly Bootstraps to provide 26 mobile markets serving 183 households, with 9,456 pounds of food. In addition made 1,415 home deliveries to three different housing sites in Beverly, serving 680 people with 42,450 pounds of food.
- ***Action Inc. Welcome Home Program*** – Through support from BH/AGH, permanent housing was secured for 11 chronically homeless individuals in FY21, and housing was maintained for 97% previously homeless program participants.
- ***Centerboard Project HOPE*** – With support from BH/AH, 42 community members were diverted from entering the shelter system in FY21.
- ***Wellspring House “Accelerating Access to Higher Education” Program*** – BH/AGH provided support to Wellspring House to provide education, job training and career advising to 150 young adults to help them obtain employment or transition to employment with higher wages.

For the FY21 reporting year, BH/AGH dedicated a great deal of time and resources at the local level in response to the COVID-19 global pandemic. BH/AGH was intentional when assessing risk factors within our CBSA and worked closely with their local health department(s). Clinical staff provided infection control expertise to local health departments during their reopening plans. BH/AGH worked to expand community testing access and worked with BILH as a system to develop and distribute written materials (in nine languages) to the communities most impacted by COVID-19, to help slow the spread. BH/AGH redeployed staff and procured tangible necessities for both the community at large and hospital staff, such as personal protective equipment (PPE), food, hand sanitizer, and other critical items. Many of the programs highlighted in this report had to be modified significantly due to COVID-19 and related safety guidelines.

Plans for Next Reporting Year:

In FY19, BH/AGH conducted a comprehensive and inclusive Community Health Needs Assessment (CHNA) that included qualitative and quantitative data collection, robust community engagement activities, and an inclusive prioritization process. These activities were in full compliance with the commonwealth's updated Community Benefits Guidelines for FY19. In response to the FY19 CHNA, BH/AGH will focus its FY20-22 Implementation Strategy on four priority areas, which collectively address the broad range of health and social issues facing residents with the greatest health disparities living in BH/AGH's CBSA. These four priority areas are:

- **Social Determinants of Health and Access to Care**
- **Chronic Disease**
- **Mental Health**
- **Substance Dependency**

These priority areas are aligned with the statewide health priorities identified by the Executive Office of Health and Human Services (EOHHS) in 2017 (i.e., Chronic Disease, Housing Stability/Homelessness, Mental Illness and Mental Health, and Substance Use Disorders). BH/AGH's priorities are also aligned with the priorities identified by the Massachusetts Department of Public Health (DPH) to guide the Community-based Health Initiative (CHI) investments funded by the Determination of Need (DoN) process, which underscore the importance of investing in the Social Determinants of Health (i.e., built environment, social environment, housing, violence, education, and employment).

The FY19 CHNA provided new guidance and invaluable insights on quantitative trends and community perceptions that are being used to inform and refine BH/AGH's efforts. In completing the FY19 CHNA and FY20-22 Implementation Strategy, BH/AGH, along with its other health, public health, social services, and community partners, is committed to improving the health status and well-being of all residents living throughout its CBSA. Based on the CHNA's quantitative and qualitative findings, including discussions with a broad range of community participants, there was agreement that BH/AGH's FY20-22 IS should prioritize certain demographic, socioeconomic, and geographic population segments that have complex needs and face barriers to care and a service gap, as well as other adverse social determinants of health. These factors put these segments at greater risk, limit their access to needed services, and can often lead to disparities in health outcomes. Four population segments were prioritized: older adults, children and families, individuals and families of low resources, and individuals with chronic/complex conditions.

SECTION II: COMMUNITY BENEFITS PROCESS

Community Benefits Leadership & Community Benefits Advisory Committee (CBAC):

The BH/AGH Community Benefits Program is spearheaded by the Regional Manager, Community Benefits/Community Relations. The Regional Manager has direct access and is accountable to the BH/AGH President and the BILH Vice President of Community Benefits and Community Relations, the latter of whom reports directly to the BILH Chief Diversity, Equity, and Inclusion Officer. It is the responsibility of these senior managers to ensure that Community Benefits is addressed by the entire organization and that the needs of underserved populations are considered every day in discussions on resource allocation, policies, and program development. This is the structure and methodology employed to ensure that Community Benefits is not the purview of one office alone and to maximize the extent to which efforts across the organization are fulfilling the mission and goals of community benefits.

The membership of the BH/AGH CBAC aspires to be representative of the constituencies and priority populations of BH/AGH programmatic endeavors, including those from diverse racial and ethnic backgrounds, ages, genders, sexual orientations, and gender identities, as well as those from corporate and nonprofit community organizations. Senior management is actively engaged in the development and implementation of the Community Benefits plan, ensuring that hospital policies and resources are allocated to support activities. It is not only the board and senior leadership that are held accountable in fulfilling the Community Benefits mission. Consistent with NHC core values is the recognition that the most successful community benefits programs are those that are implemented organization wide and integrated into the very fabric of NHC culture, policies, and procedures. It is not a stand-alone effort that is the responsibility of one staff or department, but rather an orientation and value manifested throughout the NHC structure, reflected in how it provides care at BH/AGH and in affiliated practices in urban neighborhoods and rural areas. NHC is a member of BILH. While NHC oversees local Community Benefits programming and community engagement efforts, Community Benefits is under the purview of the BILH Chief Diversity, Equity, and Inclusion Officer. This structure ensures that Community Benefits efforts, prioritization, planning, and strategy align and/or are integrated with local and system strategic and regulatory priorities.

CBAC Members:

Nancy Palmer, Board Chair, Northeast Hospital Corporation Board of Trustees
Tom Sands, President, Beverly/Addison Gilbert Hospital
Marylou Hardy, Regional Manager Community Relations/Community Benefits, NHC
Christine Healey, Director, Community Relations/Community Benefits, BILH
Jason Andree, Vice President, Addison Gilbert Hospital and Lahey Outpatient Center Danvers
Karin Carroll, Director of Community Programs, North Shore Community Health
Andrew DeFranza, Executive Director, Harborlight Community Partners
David DiChiara, MD, Associate Chief Medical Officer, Beverly/Addison Gilbert Hospital
Dutrochet Djoko, Chair of Human Rights & Inclusion Committee, Danvers Board of Health
Cindy Donaldson, Resident, Beverly/Addison Gilbert Hospital
Mark Gendreau, MD, Chief Medical Officer, Beverly/Addison Gilbert Hospital
Peggy Hegarty-Steck, President & Executive Director, Action, Inc.
Brian Holmes, Medical Assistant Educator, Beth Israel Lahey Health Primary Care
Robert Irwin, Trustee, Northeast Hospital Corporation Board of Trustees
Julie LaFontaine, President and CEO, The Open Door
Chris Lovasco, President, YMCA of the North Shore
Whitney Mcneilly, Director, DanversCARES
Chessye Moseley, Trustee, NHC Board of Trustees
Karen Neva Bell, Trustee, NHC Board of Trustees
Valerie Parker Callahan, Director, Planning & Development, Greater Lynn Senior Services
Jonathan Payson, Trustee, NHC Board of Trustees
Kimberly Perryman, Chief Nursing Officer, Beverly/Addison Gilbert Hospital
Peter Short, MD, Associate Chief Medical Officer, Beverly/Addison Gilbert Hospital
Mike Tarmey, Vice President, Bayridge Hospital

Abu Toppin, Diversity, Equity, and Inclusion Director, City of Beverly
Scott Trenti, Chief Executive Officer, SeniorCare
Carolina Trujillo, Trustee, NHC Board of Trustees
Craig Williams, Chief Operating Officer, Beverly/Addison Gilbert Hospital

CBAC Meetings:

The CBAC met four times in FY21 to oversee and provide guidance on the community benefits programs and services outlined in the FY20-22 Implementation Strategy (IS. Meeting Dates:

- November 12, 2019
- February 21, 2020
- April 30, 2020
- September 14, 2021, Annual Public Meeting

Community Partners:

BH/AGH recognizes its role as a community hospital in a larger health system and knows that to be successful it needs to collaborate with its community partners and those it serves. The BH/AGH CHNA and the associated IS were completed in close collaboration with hospital staff, health and social service partners, and the community at large. The BH/AGH Community Benefits Program exemplifies the spirit of collaboration that is a vital part of NHC's mission. Although BH/AGH serves and collaborates with all segments of the population, in recognition of its long-standing ties to the communities and the health disparities that exist for these communities, BH/AGH focuses its Community Benefits efforts on improving the health status of the low-income, underserved populations living in its CBSA. BH/AGH currently supports dozens of educational, outreach, community health improvement, and health system strengthening initiatives within its CBSA by collaborating with many of the area's leading health care, public health, and social services organizations. BH/AGH relies on its community partners to implement its Community Benefits initiatives and has leveraged their expertise and the vital connections they have with residents and other community-based organizations. The following is a list of the community partners BH/AGH collaborated with in assessing community need and IS:

- Action Inc.
- American Cancer Society
- Backyard Growers
- Beverly Bootstraps
- Cape Ann Mass in Motion
- CHNA 13/14
- City of Beverly
- City of Gloucester
- DanversCares
- Gloucester School Dept.
- MetroNorth YMCA
- North Shore YMCA
- The Open Door
- Pathways
- SeniorCare, Inc.
- Town of Danvers
- Town of Essex
- Town of Ipswich
- Town of Manchester-by-the-Sea
- Town of Middleton
- Town of Rockport
- Wellspring House

SECTION III: COMMUNITY HEALTH NEEDS ASSESSMENT

The FY19 community health needs assessment (CHNA) and the associated FY20-22 IS were developed over a ten-month period from October 2018 to August 2019. These community health assessment, planning, and implementation efforts fulfill the Commonwealth of Massachusetts Attorney General's Office and Federal Internal Revenue Service's (IRS) requirements. More specifically, these activities fulfill the BH/AGH's need to conduct a CHNA, engage the community, identify priority health issues, inventory community assets, assess impact, and develop an IS. However, these activities are driven primarily by BH/AGH's dedication to its mission, its covenant to the underserved, and its commitment to community health improvement. As mentioned, BH/AGH's most recent CHNA was completed during FY19. FY20 Community Benefits programming was informed by the FY19 CHNA and aligns with BH/AGH's FY20-22 IS. The following is a summary description of the FY19 CHNA approach, methods, and key findings.

Approach and Methods:

The assessment began with the creation of a Steering Committee composed of representatives from the former Lahey Health system, including BH/AGH, Lahey Hospital and Medical Center/Lahey Medical Center Peabody, and Winchester Hospital. The hospitals hired John Snow, Inc. (JSI), a public health research and consulting firm in Boston, to complete the CHNA and IS. The Steering Committee provided vital oversight of the CHNA approach, methods, and reporting process. This Committee met monthly, in person and via conference call, to review project activities, vet preliminary findings, address challenges, and ensure alignment in CHNA approach and methods across the BILH system.

BH/AGH engaged its Community Benefits Advisory Committee (CBAC) – made up of hospital leadership and clinical staff, local service providers, and key community stakeholders – extensively throughout this process. This group met numerous times over the course of the assessment and provided input on the assessment approach, vetted preliminary findings, and helped prioritize community health issues and vulnerable populations. The CBAC also reviewed and provided feedback on the associated IS.

The FY19 assessment was completed in three phases, which allowed BH/AGH to:

- Compile an extensive amount of quantitative and qualitative data;
- Engage and involve key stakeholders, BH/AGH clinical and administrative staff, and the community at large;
- Develop a report and detailed strategic plan; and
- Comply with all Massachusetts Attorney General and IRS Community Benefits requirements. Data sources included a broad array of publicly available secondary data, key informant interviews, and four community forums.

BH/AGH's Community Benefits Program is predicated on the notion of partnership and dialogue with its many communities. BH/AGH's understanding of these communities' needs is derived from discussions with and observations by health care and health-related workers in the neighborhoods as well as more formal assessments through available public health data, focus groups, surveys, etc. This data was then augmented by demographic and health status information gleaned from a variety of sources including the Massachusetts Department of Public Health, local health departments, federal resources such as the Institute of Medicine and Centers for Disease Control and Prevention, and from a review of literature relevant to a particular community's needs. The articulation of each specific community's needs was done in partnership between Lahey Hospital and Medical Center and BH/AGH, and in concert with community residents and leaders to design specific actions to be conducted each year. Each component of the plan is developed and eventually woven into the annual goals and agenda for the BH/AGH's Community Benefits Plan. BH/AGH's Community Relations staff, CBAC, and hospital leadership reviewed this CHNA report and IS before it was submitted to the Board of Trustees for adoption on September 5, 2019.

Summary of FY19 CHNA Key Health-Related Findings:

- 1. Social Determinants of Health (SDoH) & Access to Care:** SDoH (economic stability, transportation, access to care, housing, and food insecurity) impact many segments of the population. A major theme from the assessment's key informant interviews, focus groups, listening sessions, and Community Health Survey was the continued impact that SDoH have on residents, especially those who experience economic insecurity, mental health or substance use issues, or lack a close support system. Despite the fact that Massachusetts has one of the highest rates of health insurance enrollment, and the communities that make up BH/AGH's service area have strong, robust safety net systems, there are still substantial numbers of individuals who face health disparities and are not engaged in essential medical and behavioral health services. Efforts need to be made to expand access, reduce barriers to care, and improve the quality of primary care, medical specialty care, and behavioral health services.
- 2. Mental Health:** Mental health issues (e.g., depression, anxiety/stress, access to treatment, stigma) underlie many health and social concerns. Nearly every key informant interview, focus group, and listening session included discussions on the impact of mental health issues. From a review of the quantitative and qualitative information, depression, anxiety/stress, and social isolation were the leading concerns. There were particular concerns around the impact of depression, anxiety, and e-cigarette/vaping for youth and social isolation among older adults.
- 3. Substance Dependency:** Substance dependency continues to impact individuals, families, and communities. The opioid epidemic continues to be an area of focus in BH/AGH's service area, where many of the commonwealth's treatment services are located. Beyond opioids, key informants were also concerned with alcohol misuse, changing community norms in light of the legalization of recreational marijuana use, and e-cigarette/vaping among adolescents.

Program Name: Serving Health Information Needs of Everyone (SHINE) Program**Health Issue: Additional Needs (Access to Healthcare)****Brief Description or Objective**

The Serving the Health Information Needs of Everyone (SHINE) program and financial counselors provide health insurance counseling services to elderly and disabled adults. SHINE counselors are trained to handle complex questions about Medicare, Medicare supplements, Medicare health maintenance organizations, public benefits with health care components, Medicaid, free hospital care, prescription drug assistance programs, drug discount cards, and long-term health insurance. SHINE counselors also screen Medicare beneficiaries for public benefits eligibility – e.g., MassHealth, the Medicare Savings Program, Prescription Advantage, Health Safety Net, free care/discounted prescriptions, and referrals to connect people with fuel assistance, home care, and food. Each SHINE counseling session is documented with data collected and stored in the Administration for Community Living STARS database used to analyze national, state, and local trends and capture consumer demographics.

Program Type

- Direct Clinical Services
 Community Clinical Linkages
 Total Population or Community Wide Intervention
- Access/Coverage Supports
 Infrastructure to Support Community Benefits

Program Goal(s)

To help Medicare beneficiaries and their caregivers navigate their health insurance options. The counselors are also available to review current coverage, compare costs and benefits of available options, and assist those with limited resources in enrolling in helpful programs

Goal Status

In FY21, In FY21, due to COVID restrictions, SHINE counselors conducted visits/sessions via telephone. There were 3682 visits conducted for residents of the North Shore and Cape Ann; a 14% increase over FY20. Of the 3682 sessions conducted, Hospital staff conducted 3,519 and 163 were conducted by a Shine Volunteer.

Program Year: Year 3**Of X Years: Year 3****Goal Type: Process Goal****Program Name: Interpreter Services****Health Issue: Additional Needs (Access to Healthcare)****Brief Description or Objective**

Research shows the health disparities and differences in health care access and utilization that exist for diverse individuals/cohorts and foreign-born populations, language barriers pose significant challenges to providing effective and high-quality health and social services. Recognizing that language and cultural barriers are major barriers to accessing health and social services and navigating the health system, NHC offers an extensive interpreter services program that provides interpretation (translation) and assistance in over 60 different languages, including American Sign Language, and hearing augmentation devices for those who are hard of hearing. The interpreter services program also routinely facilitates access to care, helps patients understand their course of treatment, and helps patients adhere to discharge instructions and other medical regimens.

Program Type

- Direct Clinical Services
 Community Clinical Linkages
 Total Population or Community Wide Intervention
- Access/Coverage Supports
 Infrastructure to Support Community Benefits

Program Goal(s)

To provide culturally responsive care through Interpreter Services Department.

Goal Status

In FY21, NHC interpreters reported a total of 11,480 encounters: 10,719 at Beverly Hospital and 761 at Addison Gilbert Hospital. The top three languages were: Spanish – 1747, Portuguese – 721, Albanian - 172

Program Year: Year 3**Of X Years: Year 3****Goal Type: Outcomes Goal**

| | |
|---|--|
| Program Name: The Open Door Food is Medicine Program | |
| Health Issue: Additional Needs (Access to Healthy Foods) | |
| Brief Description or Objective | Access to healthy food is a vital component to achieving good health. Beverly and Addison Gilbert Hospital provided financial support to The Open Door to provide the Food is Medicine program, which aims to alleviate hunger in the community by ensuring that low-income, food-insecure people struggling with or at risk of chronic illness have access to healthy foods along with free nutritional counseling and educational workshops for healthy meal planning. |
| Program Type | <input type="checkbox"/> Direct Clinical Services <input type="checkbox"/> Access/Coverage Supports <input type="checkbox"/> Community Clinical Linkages <input type="checkbox"/> Infrastructure to Support Community Benefits <input checked="" type="checkbox"/> Total Population or Community Wide Intervention |
| Program Goal(s) | <ul style="list-style-type: none"> • Manage nutrition boxes targeted for clients to better manage health/diet • Provide at least 16 community nutrition workshops for adults/families • Provide free nutrition counseling for food insecure low-income people at risk of chronic disease. |
| Goal Status | <ul style="list-style-type: none"> • Completed 14 Community Workshops: 5 senior workshops impacting 51 seniors; 9 family workshops impacting 89 participants. 93% Learned something new 93% Will make healthier choices 93% Would attend another workshop 90% Would refer a friend to a workshop • Registered Dietitian managed and provided programs through which food insecure individuals who had or are at-risk of developing chronic illness could access nutrition counseling and therapy |
| Program Year: Year 3 | Of X Years: Year 3 |
| Goal Type: Outcomes Goal | |

| | |
|--|---|
| Program Name: Beverly Bootstraps Mobile Market | |
| Health Issue: Additional Needs (Access to Healthcare) | |
| Brief Description or Objective | Through financial support from Beverly/Addison Gilbert Hospital a summer mobile market was offered at the Beverly Senior Center to bring a free, fresh produce along with nutrition information to residents of Beverly Housing and seniors at the Beverly Council on Aging. In addition, BH/AGH provided funding to support the Senior Home Delivery Program, initiated to ensure low-income seniors in Beverly would receive bags of food that they otherwise would have had to leave their home to acquire at either our Food Pantry or the local grocery store, placing them at an increased risk of exposure to COVID-19. |
| Program Type | <input type="checkbox"/> Direct Clinical Services <input type="checkbox"/> Access/Coverage Supports <input type="checkbox"/> Community Clinical Linkages <input type="checkbox"/> Infrastructure to Support Community Benefits <input checked="" type="checkbox"/> Total Population or Community Wide Intervention |
| Program Goal(s) | <ol style="list-style-type: none"> 1. To provide a free fresh traveling farmers market to our Beverly Housing clients and seniors during the summer and fall of 2021. 2. To provide low income residents home delivery of meals |
| Goal Status | <ol style="list-style-type: none"> 1. In FY21 26 mobile markets were held, serving 183 households, with 9,456 pounds of food. Due to Covid restrictions at the Beverly Senior Center, the markets were held at housing facilities in Beverly including Apple Village, Turtle Creek, and Turtle Woods. 2. In FY21 1,415 home deliveries were made to three different housing sites in Beverly, serving 680 people with 42,450 pounds of food. The deliveries were made to the following housing locations in Beverly: Turtle Creek (1141), Federal Street (51), Bach Street (38), Garden City Tower (148), and Herrick Street (13) |
| Program Year: Year 3 | Of X Years: Year 3 |
| Goal Type: Process Goal | |

Program Name: Connecting Young Moms**Health Issue: Additional Health Needs (Access to Health Care)****Brief Description or Objective**

The Connecting Young Moms (CYM) program offers comprehensive pre- and postnatal programs to young mothers and their children with limited resources or emotional/social support. The prenatal component of the CYM program is the Childbirth Preparation Series, designed to prepare expectant mothers and their support people for labor and delivery. The postnatal component is a support group specifically for teens and young women and their children. Until mid-March, the group met in person and child care was provided. From mid-March through the end of the year, the program has been delivering postnatal services remotely. Topics include healthy relationships, challenges of young parenthood, balancing parenting/work/education, child development, and coping with the isolation, stress, job loss, and other challenges associated with COVID-19. The CYM program also provides extensive resource and referral support to women who do not fully join the program, and those not actively participating.

Program Type

- Direct Clinical Services
 Access/Coverage Supports
 Community Clinical Linkages
 Infrastructure to Support Community Benefits
 Total Population or Community Wide Intervention

Program Goal(s)

1. Increase the number of referrals into the program
2. Reduce barriers to participation during COVID by transitioning support groups to a virtual platform and ensuring all clients have access to technology.

Goal Status

1. There were 55 new referrals in FY21. Of those, 15% were non-English speaking, and 58% were 20 years old or younger.
2. 100% of the groups in FY21 were held virtually and laptops were provided to the 13% of participants to increase access.

Program Year: Year 3**Of X Years: Year 3****Goal Type: Process Goal****Program Name: Home Blood Draw Program****Health Issue: Chronic Disease & Additional Health Needs (Access to Care)****Brief Description or Objective**

The BH/AGH Laboratory Homebound Phlebotomy Program provides free phlebotomy services in the home for patients who are homebound due to illness or injury, or those with transportation challenges.

Program Type

- Direct Clinical Services
 Access/Coverage Supports
 Community Clinical Linkages
 Infrastructure to Support Community Benefits
 Total Population or Community Wide Intervention

Program Goal(s)

Increase access to phlebotomy services for homebound patients who have difficulty getting to a laboratory/drawing station due to illness or injury.

Goal Status

In FY21, the Mobile Phlebotomy Team from BH/AGH Laboratory scheduled and performed approximately 5,761 free homebound lab visits. Patients have reported reduced feelings of isolation because the visit with the phlebotomist provided them with a social opportunity, and the ability to comply with necessary testing. Patient population served is primarily the elderly and disabled.

Program Year: Year 3**Of X Years: Year 3****Goal Type: Process Goal**

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|---|---|
| Program Name: Centerboard Project Hope | |
| Health Issue: Housing Stability | |
| Brief Description or Objective | Beverly and Addison Gilbert provided financial support to Centerboard to support Project Hope, a program that seeks to increase access to permanent housing and prevent homelessness in Lynn and surrounding cities and towns in the North Shore. Through the funding support provided, Centerboard was able to provide emergency housing to homeless residents and families, and facilitate transition to safe, permanent housing. |
| Program Type | <input type="checkbox"/> Direct Clinical Services <input type="checkbox"/> Community Clinical Linkages <input checked="" type="checkbox"/> Total Population or Community Wide Intervention <input type="checkbox"/> Access/Coverage Supports <input type="checkbox"/> Infrastructure to Support Community Benefits |
| Program Goal(s) | By the end of FY21 program participants will: <ul style="list-style-type: none"> •Be diverted from entering the shelter system (100%) •Exit the program with at least 2 resources aimed at stabilize in place (100%). •Achieve permanent housing on their own within 12 months (85%) •Achieve at least 40% improvement in physical or mental health symptoms (100%) •Increase their income by at least 25% (100%) |
| Goal Status | In FY21 40 community members were reached/served. <u>Demographic Profile:</u> Race: 23.4% were black, 23.4% multiracial, 17% white Ethnicity: 36% were Hispanic/Latino Age: 45% 25-44, 34% 18-24, 21.4% 45-64 Gender: 70.4% Female / 23.6% male <u>Results Achieved:</u> <ul style="list-style-type: none"> •100% diverted from entering the shelter system •100% exited the program with two or more new community resources to stabilize in place. •85% achieved permanent housing on their own within 12 months •82% achieved at least 40% improvement in physical or mental health symptoms •100% increase their income by at least 25% (100%) |
| Program Year: Year 1 | Of X Years: Year 3 |
| Goal Type: Outcomes Goal | |

| | |
|---|--|
| Program Name: Metro North YMCA Herring Community Technology Center | |
| Health Issue: Additional Needs (Access to Health Care) | |
| Brief Description or Objective | Beverly/Addison Gilbert Hospital provided support to the Metro North YMCA for development of a new technology center called The Herring Community Technology Center. The Center is a new space within the Metro North YMCA, which aims to bridge the digital divide by making internet services more accessible for residents in the City of Lynn. |
| Program Type | <input type="checkbox"/> Direct Clinical Services <input type="checkbox"/> Community Clinical Linkages <input checked="" type="checkbox"/> Total Population or Community Wide Intervention <input type="checkbox"/> Access/Coverage Supports <input type="checkbox"/> Infrastructure to Support Community Benefits |

| | | |
|-----------------------------|--|--------------------------------|
| Program Goal(s) | <ul style="list-style-type: none"> • Procure physical space and equipment for the technology center opening in FY21. • Develop program plan including schedule, offerings, and curriculum • Recruit, Hire, and Onboard Tech Center Staff from LV Technical Institute • Address the Digital Divide” and increase health equity for low income residents in Lynn by providing computer access and educational programs for low income residents with limited or no access to technology. | |
| Goal Status | <ul style="list-style-type: none"> • Established physical space and procured equipment for the technology center opening. • Developed program plan including schedule, offerings, and curriculum • Served more than 200 low income residents of Lynn in FY21 | |
| Program Year: Year 1 | Of X Years: Year 3 | Goal Type: Process Goal |

| | | |
|--|--|---------------------------------|
| Program Name: Cape Ann “Addressing the Digital Divide Program | | |
| Health Issue: Additional Health Needs (Digital Divide) | | |
| Brief Description or Objective | In response to COVID epidemic, with funding provided by Beverly and Addison Gilbert Hospital, Cape Ann Mass in Motion/Seniors on the Go partnered with the Gloucester Housing Authority, Council on Aging, and long term care facilities to expand their technological infrastructure, providing a vital link for residents to access equipment, internet, and provide education to increase their technology skills to help them access affordable, healthy food, fitness classes and medical appointments via telehealth. | |
| Program Type | <input type="checkbox"/> Direct Clinical Services <input type="checkbox"/> Access/Coverage Supports <input type="checkbox"/> Community Clinical Linkages <input type="checkbox"/> Infrastructure to Support Community Benefits <input checked="" type="checkbox"/> Total Population or Community Wide Intervention | |
| Program Goal(s) | As reported by participants, along with analysis of utilization rates of online ordering, by the end of FY2, low income residents will increase: <ul style="list-style-type: none"> • Access to healthy foods by 10%. • Increase internet literacy by 10% • Increase rates of socialization and improved mental health status by 10% • Increase physical activity by 1 hour per week/4 days per month. | |
| Goal Status | In FY21 77 community members were reached/served. <u>Demographic Profile:</u> Race: 23.4% were black, 23.4% multiracial, 17% white Ethnicity:36% were Hispanic/Latino Age:45% 25-44, 34% 18-24, 21.4% 45-64 Gender: 70.4% Female / 23.6% male As reported by participants and/or analysis of online utilization rates, the following outcomes were achieved: <ul style="list-style-type: none"> • Increased access to healthy foods by 10%. • Increased internet literacy by 10% • Participants improved rates of socialization and mental health status by 10% • Increased physical activity by 1 hour per week/4 days per month. | |
| Program Year: Year 1 | Of X Years: Year 3 | Goal Type: Outcomes Goal |

Program Name: Action Inc. Welcome Home Program**Health Issue: Housing Stability****Brief Description or Objective**

Through support from BH/AGH, Action Inc., this program provides permanent housing and supportive services to chronically homeless individuals and families in accordance with the Housing First model. To participate in the program, clients must have long histories of homelessness and at least one disabling condition.

Program Type

- | | |
|---|---|
| <input type="checkbox"/> Direct Clinical Services | <input type="checkbox"/> Access/Coverage Supports |
| <input type="checkbox"/> Community Clinical Linkages | <input type="checkbox"/> Infrastructure to Support Community Benefits |
| <input checked="" type="checkbox"/> Total Population or Community Wide Intervention | |

Program Goal(s)

The overall goal of the program is to provide chronically homeless people with permanent housing; to help clients maintain that housing; to ensure clients are connected to mainstream health care services; to improve clients' overall health; to improve our clients' mental and behavioral health specifically; and to help clients achieve their self-identified goals for the future.

1. Place 8 chronically homeless individuals into permanent supportive housing by the end of FY21.
2. In FY21, 90% of formerly homeless clients in the Welcome Home program will follow through on referrals from a PCP.
3. During FY21, 95% of formerly homeless clients in the program will retain their housing.
4. Decrease Emergency Department usage among clients by 25%.

Goal Status

1. Eleven chronically homeless individuals moved into permanent supportive housing in FY21.
2. 89% of formerly homeless clients in the Welcome Home program who received referrals followed through with PCP appointments. Some clients were unable to visit their PCP due to the pandemic.
3. 96% of formerly homeless clients in the program retained their housing.

Program Year: Year 3**Of X Years: Year 3****Goal Type: Outcomes Goal****Program Name: City of Beverly Summer Literacy Program****Health Issue: Additional Needs (Access to Healthcare)****Brief Description or Objective**

The Summer Literacy Program provided learning opportunities and enrichment experiences to children reading below grade level and at risk of experiencing summer learning loss. Building a Better Beverly, in partnership with Beverly Public Schools and the Greater Beverly YMCA, provided a six-week, free summer learning program to approximately 180 children entering first, second, and third grade. The day camp included three hours of literacy instruction in the morning and a traditional summer camp experience in the afternoon. Children received instruction on spelling, grammar, vocabulary, self-selected reading, and small-group guided reading. Programming at Sterling YMCA also included enrichment activities such as arts and crafts, music, team-building activities, swimming, and more.

Program Type

- | | |
|---|---|
| <input type="checkbox"/> Direct Clinical Services | <input type="checkbox"/> Access/Coverage Supports |
| <input type="checkbox"/> Community Clinical Linkages | <input type="checkbox"/> Infrastructure to Support Community Benefits |
| <input checked="" type="checkbox"/> Total Population or Community Wide Intervention | |

Program Goal(s)

The goals of the program are to help all kids achieve grade-level literacy, and provide a summer camp opportunity to help these children grow healthy and happy.

Priority Area #2: Chronic Disease/Complex Conditions

| | |
|--|--|
| Program Name: Breast Cancer Risk Assessment | |
| Health Issue: Chronic Disease | |
| Brief Description or Objective | Recognizing the risk for breast cancer is not the same for all women, BH/AGH implemented a free risk assessment using a tablet screening tool to help women evaluate their lifetime risk for breast cancer. The assessment includes an evaluation using the tool, and results, which are shared with the person's physician, are reviewed in a follow up consultation to determine if they might benefit from a higher level of screening beyond regular checkups and mammograms. |
| Program Type | <input checked="" type="checkbox"/> Direct Clinical Services <input type="checkbox"/> Access/Coverage Supports <input type="checkbox"/> Community Clinical Linkages <input type="checkbox"/> Infrastructure to Support Community Benefits <input type="checkbox"/> Total Population or Community Wide Intervention |
| Program Goal(s) | Goal: To identify persons who may be at higher lifetime risk of developing breast cancer and to provide screening follow-up to their physicians. |
| Goal Status | <p>In FY21, BH/AGH conducted 3089 free screenings in Beverly, Addison Gilbert Hospital, and the Danvers Outpatient Center, identifying 221 patients with a high-risk mutation and 312 patients with a high lifetime risk of breast cancer. Follow-up consultations were provided after each screening, and results were shared with the participant's physicians so they could discuss the recommended follow-up evaluation and care.</p> <p><u>Demographic Profile:</u> 20-39: 143 40-59: 1586 60-79: 1309 80 +: 51</p> |
| Program Year: Year 3 | Of X Years: Year 3 |
| Goal Type: Outcomes Goal | |

| | |
|---|---|
| Program Name: School Based Health Center at Gloucester High School | |
| Health Issue: Chronic Disease & Additional Needs (Food Access) | |
| Brief Description or Objective | <p>Access to a consistent source of primary care is particularly important since it greatly affects the individual's ability to receive regular preventive, routine, and urgent care and to manage chronic diseases. This program increases access to healthcare by providing high-quality, comprehensive health care to students on-site at Gloucester High School in order to support optimal health and academic outcomes. The health clinic is a branch of Addison Gilbert Hospital and is supported in part by a grant from the Massachusetts DPH. Services include management of chronic illnesses such as asthma and diabetes, urgent care visits, immunizations, routine and sports physicals, health education, and confidential services, including reproductive health care and behavioral health services. In addition, the SBHC is a safe place where students are encouraged through a strengths-based approach and motivational interviewing to discuss important personal topics such as stress, exercise, healthy eating, alcohol and drug use, friendship, sexual health, and other personal health issues.</p> <p>The SBHC provides an integrated model of care in its approach, staffed by a Nurse Practitioner, a Licensed Independent Clinical Social Worker, and a Certified Community Health Worker.</p> <p>To address the community's food insecurity issues impacted by Covid, the SBHC collaborated with the Open Door to implement a Free Food Locker, a program designed to provide students, who returned to in-person learning, the opportunity to bring free food home to their families.</p> |

| | | |
|-----------------------------|--|--|
| Program Type | <input checked="" type="checkbox"/> Direct Clinical Services <input type="checkbox"/> Community Clinical Linkages <input type="checkbox"/> Total Population or Community Wide Intervention | <input type="checkbox"/> Access/Coverage Supports <input type="checkbox"/> Infrastructure to Support Community Benefits |
| Program Goal(s) | <ul style="list-style-type: none"> - Provide high-quality, comprehensive health care to students to support optimal health and academic outcomes. - Initiated collaboration with The Open Door Food Pantry to implement the Free Food Locker shelf pantry to address gaps in food security for GHS students/families - Lead a Walking Club to encourage students to exercise, instill healthy life choices, and provide a space to discuss topics important to teens while students earn gym credits required for graduation | |
| Goal Status | <ul style="list-style-type: none"> - The clinic conducted 567 nurse practitioner visits and 637 social worker visits, in person or via telehealth, and completed 1958 assessments. - Reduced barriers to food access that existed both pre-pandemic and during the pandemic. - Organized 21 outreach activities such as social skills work groups and reproductive health classes. - Delivered 449 food orders via 336 contactless deliveries to 56 students and their families. - Conducted 60 walking sessions for 7 GHS students. Topics discussed included gender identity, racial equity, and nutrition. | |
| Program Year: Year 3 | Of X Years: Year 3 | Goal Type: Process Goal |

| | | |
|---|---|--|
| Program Name: North Shore YMCA Enhance Fitness Program | | |
| Health Issue: Chronic Disease | | |
| Brief Description or Objective | <p>Over the past two decades, obesity rates in the United States have doubled for adults. Overall fitness and physical activity reduce the risk for many chronic diseases, are linked to good emotional health, and help prevent disease. Through a partnership with the North Shore YMCA, Enhance Fitness classes are offered for free at the YMCA and various locations in the community. Enhance Fitness is an evidence-based health intervention offsetting the effects of aging and chronic illness as well as minimizing fall risk. Participants work on cardio and muscular strength, balance, flexibility, and stability, all while engaging in a supportive social community. Classes meet three days per week, and sessions run for eight weeks. Fitness checks are done at the beginning and end of each sixteen-week session. Due to COVID restrictions, in FY21 classes were conducted virtually via Zoom.</p> | |
| Program Type | <input type="checkbox"/> Direct Clinical Services <input type="checkbox"/> Community Clinical Linkages <input checked="" type="checkbox"/> Total Population or Community Wide Intervention | <input type="checkbox"/> Access/Coverage Supports <input type="checkbox"/> Infrastructure to Support Community Benefits |
| Program Goal(s) | <ol style="list-style-type: none"> 1. To provide Enhance Fitness classes in person 2. To provide Enhance Fitness classes virtually via Zoom during COVID restrictions, and after for those not comfortable meeting in person. 3. To increase participant's general health, physical ability, and physical activity level. | |
| Goal Status | <p>In FY21 69 community members participated in Enhance Fitness classes:</p> <ol style="list-style-type: none"> 1. In-person sessions were held at three different YMCA locations reaching 41 participants overall. <p><u>Demographic Profile:</u> Ipswich: Ages 70-89, 69% female and 31% male Gloucester: Ages 60-90+, 91% female and 9% male</p> | |

| | | |
|-----------------------------|---|---------------------------------|
| | <p>Beverly: Ages 60-89, 65% female and 35% male</p> <p>2. Three sessions were held virtually via Zoom reaching 28 people</p> <p><u>Demographic Profile:</u></p> <p>25 Female/3 male, ages 60-89 with majority between 70-79</p> <p>3. As per a pre and post survey, the following results were achieved according to age predicted norms:</p> <ul style="list-style-type: none"> • An average of 74% improved to “above average” leg strength • An average of 83% improved to “above average” or maintained at “average” upper body strength • An average of 37% improved mobility/balance | |
| Program Year: Year 3 | Of X Years: Year 3 | Goal Type: Outcomes Goal |

| | | |
|---|---|---------------------------------|
| <p>Program Name: Oncology Nurse Navigators</p> <p>Health Issue: Additional Needs (Access to Healthcare)</p> | | |
| Brief Description or Objective | <p>The Oncology Nurse Navigator is an RN with oncology-specific clinical knowledge. These Navigators offer individualized support and assistance to patients and their caregivers to help them make informed decisions about their care and to overcome barriers to optimal care. The Navigator contributes to the Hospital’s mission by providing cancer patients with coordinated care through a holistic and collaborative approach that includes communication and coordination with the patient’s family and/or caregivers along with a multidisciplinary team consisting of physicians, nurse practitioners, oncology nurses, and social workers. The Navigator works in collaboration with the clinical team to develop clinical pathways for appropriate care, and acts as the contact clinical person in resolving all patient-related concerns. The Navigator ensures all medical information has been received by physicians, reviews all medical information prior to a patient visit, and discusses any concerns with the provider prior to the patient visit. The Navigator maintains contact with referring and other collaborating physicians to keep them up to date on the patient’s care plan. In addition, the Nurse Navigator connects patients with resources, including health care and support services in their communities, and assists them in the transition from active treatment to survivorship.</p> | |
| Program Type | <p> <input type="checkbox"/> Direct Clinical Services <input type="checkbox"/> Access/Coverage Supports <input checked="" type="checkbox"/> Community Clinical Linkages <input type="checkbox"/> Infrastructure to Support Community Benefits <input type="checkbox"/> Total Population or Community Wide Intervention </p> | |
| Program Goal(s) | <p>To guide patients through the complexities of the disease, direct them to health care services for timely treatment and into survivorship, and actively identify and help address barriers to care that might prevent them from receiving timely and appropriate treatment.</p> | |
| Goal Status | <p>In FY21 the Oncology Nurse Navigators at BH and AGH supported 823 patients. In addition to the ongoing support of existing patients and their families/caregivers under care of the hematology-oncology provider.</p> | |
| Program Year: Year 3 | Of X Years: Year 3 | Goal Type: Outcomes Goal |

| | |
|--|--|
| Program Name: High Risk Intervention Team | |
| Health Issue: Chronic Disease | |
| Brief Description or Objective | The High Risk Intervention Team (HRIT) is a multidisciplinary team with pharmacists, social workers, and recovery coaches that provides a multitude of services to high-risk clients to support their complex needs, including medication education, home visits, accompaniment to medical appointments, coordinating discharge care, assistance with obtaining insurance, coordinating mental health and recovery services for substance use disorders, housing needs, accessing food, and any and all interventions designed to assist patients to be cared for in their homes or community setting. The HRIT also makes post-acute care and home visits. In addition, a recovery coach on the team is designated to the emergency department to work directly with patients with substance use disorder that present to the ED. The recovery coach is able to provide immediate recovery options. |
| Program Type | <input checked="" type="checkbox"/> Direct Clinical Services <input type="checkbox"/> Access/Coverage Supports <input type="checkbox"/> Community Clinical Linkages <input type="checkbox"/> Infrastructure to Support Community Benefits <input type="checkbox"/> Total Population or Community Wide Intervention |
| Program Goal(s) | The HRIT will serve the community population with the highest risk for readmission to BH/AGH, including those with four or more admissions in the past 12 months, those with readmissions within 30 days, and those with socially complex needs (Medicaid, Medicare, homelessness, and substance use disorder history). |
| Goal Status | The HRIT serves a monthly average of 90 patients at AGH and 330 at BH on an ongoing basis. Of these patients 80% have a public payor (Medicare or Medicaid) and 40% had a mental health diagnosis or substance use disorder. |
| Program Year: Year 3 | Of X Years: Year 3 |
| Goal Type: Process Goal | |

Priority Area #3: Substance Dependency

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|---|--|
| Program Name: Ryan Recovery House | |
| Health Issue: Substance Use Disorder | |
| Brief Description or Objective | Ryan House is a treatment-focused halfway house that provides services to those who seek recovery from addiction and related mental health issues. Services include a broad range of outpatient, inpatient and residential care, including 24 hour staff supervision, individualized treatment planning with case management services to assist in the recovery process, group and individual therapy, employment counseling, relapse prevention, anger management, life skills training, daily self-help meetings, and specialized services for the chronically homeless. |
| Program Type | <input type="checkbox"/> Direct Clinical Services <input type="checkbox"/> Access/Coverage Supports <input checked="" type="checkbox"/> Community Clinical Linkages <input type="checkbox"/> Infrastructure to Support Community Benefits <input type="checkbox"/> Total Population or Community Wide Intervention |
| Program Goal(s) | Provide 24 hour support services in a structured environment for people in early recovery from drug and/or alcohol addiction. |
| Goal Status | In FY21161 patients received treatment services. |
| Program Year: Year 3 | Of X Years: Year 3 |
| Goal Type: Process Goal | |

SECTION V: EXPENDITURES

| Item/Description | FY21 Amount | Subtotal Amount Provided to Community Organizations |
|---|------------------------|---|
| Direct Clinical Services | \$11,518,068.00 | \$257,433.00 |
| Community-Clinical Linkages | \$449,171.00 | \$0.00 |
| Total Population or Community Wide Interventions | \$654,236.00 | \$250,668.00 |
| Access/Coverage Supports | \$1,414,875.08 | \$81,510.00 |
| Infrastructure to Support CB Collaborations | \$14,087.00 | \$0.00 |
| Total by Program Type | \$14,050,437.08 | \$589,611.00 |
| Chronic Disease | \$7,538,668.17 | \$410,331.00 |
| Mental Health/Mental Illness | \$4,433,826.35 | \$0.00 |
| Substance Use Disorders | \$307,409.40 | \$7,500.00 |
| Housing Stability/Homelessness | \$88,353.15 | \$40,000.00 |
| Additional Health Needs Identified by the Community | \$1,682,180.02 | \$131,780.00 |
| Total by Health Need | \$14,050,437.09 | \$589,611.00 |
| Leveraged Resources | \$3,141,990.00 | |
| Total Direct CB Programming | \$17,192,427.09 | |
| HSN Assessment | \$2,240,690.00 | |
| HSN Denied Claims | \$1,111,026.00 | |
| Free/Discount Care | \$0.00 | |
| Total Net Charity Care | \$3,351,716.00 | |
| Total CB Expenditures | \$20,544,143.09 | |
| Additional Information | | |
| Net Patient Services Revenue | \$384,997,000.00 | |
| CB Expenditure % of Net Patient Services Revenue | 5.34% | |
| Optional Information | | |
| Bad Debt Certifications | \$2,732,049.00 | |

SECTION VII: HOSPITAL SELF-ASSESSMENT FORM

Hospital Self-Assessment Update Form – Years 2 and 3

Note: This form is to be completed in the two Fiscal Years following the hospital's completion of its triennial Community Health Needs Assessment

I. Community Benefits Process:

- Has there been any change in composition or leadership of the Community Benefits Advisory Committee in the past year? Yes No
- If so, please list updates:
Northeast Hospital Corporation (NHC), comprised of Beverly, Addison Gilbert, Bayridge hospitals, and Lahey Outpatient Center Danvers, have worked to align its Community Benefits Advisory Committee (CBAC) membership to reflect the demographics included in BH/AGH's Community Benefits Service Area (CBSA), and to include residents and the following sectors; transportation agency, education, and municipal staff. FY21 CBAC Members: Chair – Nancy Palmer, Jason Andree, AGH, Karin Carroll, Gloucester Health Department. Andrew DeFranza, Harborlight Community Partners, David DiChiara, M.D., NHC, Dutrochet Djoko, Danvers BOH & Chair of Human Rights & Inclusion Committee, Cindy Donaldson, Resident, Mark Gendreau, M.D., NHC, Marylou Hardy, BILH, Christine Healey, BILH, Peggy Hegarty-Steck, Action, Inc., Brian Holmes, BILH, Robert Irwin, NHC Board, Julie LaFontaine, The Open Door, Chris Lovasco, North Shore YMCA, Whitney McNeilly, DanversCARES, Chessye Mosley, Resident, Karen Neva Bell, NHC Board, Valerie Parker Callahan, Greater Lynn Senior Services & MA Coordinating Council for Community Transportation, Jonathan Payson, NHC Board, Kim Perryman, NHC, Tom Sands, NHC, Peter Short, M.D., NHC, Mike Tarmey, NHC, Abu Toppin, Beverly BOH and DEI Committee, Scott Trenti, SeniorCare, Carolina Trujillo, NHC Board, Craig Williams, NHC. The following new members were added to the CBAC in FY21: Dutrochet Djoko, Danvers BOH & Chair of Human Rights & Inclusion Committee, Sector: Public Health/BOH, Peggy Hegarty-Steck, Action, Inc., Sector: Social Services, Brian Holmes, BILH, Sector: Medical Staff, Whitney McNeilly, DanversCARES, Sector: Education, Valerie Parker Callahan, Greater Lynn Senior Services & MA Coordinating Council for Community Transportation, Sector: Transportation Abu Toppin, Beverly BOG and Diversity, Equity, & Inclusion Committee, Sector: Municipal

II. Community Engagement:

If there have been any updates to the key partners with whom the hospital collaborates, please indicate in the table below.

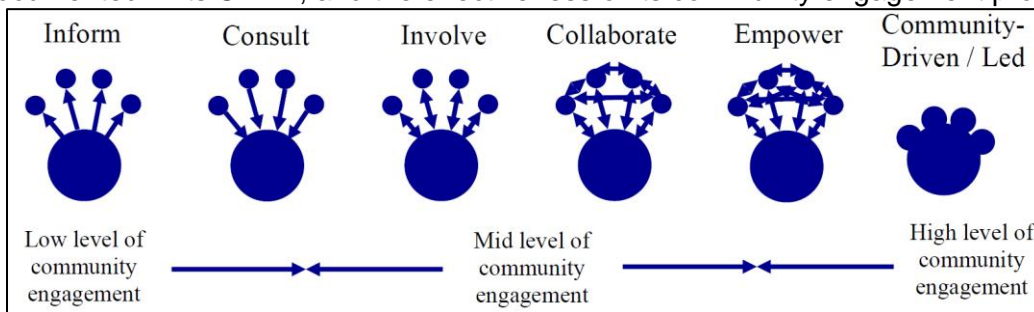
Key Updates: In FY21, NHC dedicated a great deal of time and resources to communities in its CBSA in response to urgent needs that emerged as a result of COVID-19. Working closely with local health departments and community partners, additional funding and support was provided to the community organizations to address the priority needs and populations most impacted. See Covid question for specific examples.

Listed below are a few examples:

1. In May, 2021, due to COVID restrictions for holding any indoor in-person events, NHC provided financial support to the Gloucester Senior center to provide a drive up event where seniors could pick up a healthy meal, along with educational information about preventing the spread of Covid, and personal protection equipment including hand sanitizer, face masks, etc.
2. Funding was provided to local food banks who provided drive through deliveries of groceries and household items to residents in need.
3. Funding was provided to address the digital divide and increase internet access for vulnerable populations; The Herring Community Technology Center in Lynn, and the Cape Ann Mass in Motion.
4. Funding was provided to centerboard's project Hope to increase access to permanent, safe housing for residents in Lynn and surrounding communities.

| Organization | Name and Title of Key Contact | Organization Focus Area | Brief Description of Engagement |
|--|--------------------------------------|------------------------------|---------------------------------|
| North Shore YMCA | Chris Lovasco, CEO | Social service organizations | CBAC Member |
| The Open Door | Julie LaFontaine, Executive Director | Social service organizations | CBAC Member |
| SeniorCare | Scott Trenti, Executive Director | Social service organizations | CBAC Member |
| Gloucester Health Department | Karin Carroll, Health Director | Local Health Department | CBAC Member |
| Harborlights Community Partners | Andrew DeFranza, Executive Director | Housing organizations | CBAC Member |
| Action Inc. | Peggy Hegarty-Steck | Social service organizations | CBAC Member |
| Beverly Health Department/Diversity Equity & Inclusion Committee | Abu Toppin | Local Health Department | CBAC Member |
| Beverly Bootstraps | Susan Gabriele, Executive Director | Social service organizations | Community Partner |
| DanversCares | Whitney McNeilly, Executive Director | Schools | CBAC Member |

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



| Category | Level of Engagement | Did Engagement Meet Hospital's Goals? | Goal(s) for Engagement in Upcoming Year(s) |
|----------|---------------------|---------------------------------------|--|
| | | | |

¹ "Community Engagement Standards for Community Health Planning Guideline," Massachusetts Department of Public Health, available at: <http://www.mass.gov/eohhs/docs/dph/quality/don/guidelines-community-engagement.pdf>. For a full description of the community engagement spectrum, see page 11 of the Attorney General's Community Benefits Guidelines for Non-profit Hospitals.

| | | | |
|--|-------------|-----|-------------|
| Overall engagement in developing and implementing filer's plan to address significant needs documented in CHNA | Collaborate | Yes | Collaborate |
| Determining allocation of hospital Community Benefits resources/selecting Community Benefits programs | Collaborate | Yes | Collaborate |
| Implementing Community Benefits programs | Empower | Yes | Empower |
| Evaluating progress in executing Implementation Strategy | Collaborate | Yes | Collaborate |
| Updating Implementation Strategy annually | Collaborate | Yes | Collaborate |

- For categories where community engagement did not meet the hospital's goal(s), please provide specific examples of planned improvement for next year: NA, met goals
NHC remains committed to community engagement. During FY22, NHC will undertake its triennial Community Health Needs Assessment and prioritization process. Guided by NHC's Community Benefits Advisory Committee and conducted in collaboration with community partners, this initiative's guiding principles include community engagement, equity, collaboration and capacity building. In FY22, NHC will continue to work with its CBAC and community partners to engage the community including holding an annual public meeting. Additionally, NHC will engage with our community by inviting key community partners who reach diverse and hard to reach populations to participate in the FY22 CHNA by
 - Hosting and co-facilitating a focus group session for their residents/participants; Lynn Shelter, DanversCares, and Action Inc.
 - Convening a group of town/municipal leaders to participate in a group interview
 - Participating in a Key Informant Interview
 - co-facilitating a Community Listening Session

COVID Question: Please describe how the COVID-19 pandemic impacted the hospital's process for engaging its community and developing responsive Community Benefits programming.

In FY21 NHC dedicated a great deal of time and resources at the local level in response to the COVID-19 global pandemic. NHC was intentional when assessing risk factors within our CBSA and worked closely with our local health department(s). Clinical staff provided infection control expertise to local health departments during their reopening plans. NHC worked to expand community testing access and worked with BILH as a system to develop and distribute written materials (in nine languages) to the communities most impacted by COVID-19, to help slow the spread. NHC redeployed staff and procured tangible necessities for both the community at large and hospital staff, such as personal protective equipment (PPE), food, hand sanitizer, and other critical items. In addition, NHC worked closely with local health departments and community partners to identify the most urgent needs that emerged as a result of COVID-19, and Community Benefits program funding was reallocated to address these priority needs, and the populations most impacted. Listed below are a few examples:

1. Gloucester Senior Center “Grab & Go” drive through event where seniors could pick up a healthy meal, educational information about preventing the spread of Covid, and personal protection equipment including hand sanitizer, face masks, etc.
2. Funding provided to local food banks to provide drive through deliveries of groceries and household items to residents in need.
3. Programming to address the digital divide and increase internet access for vulnerable populations; The Herring Community Technology Center in Lynn, and the Cape Ann Mass in Motion.
4. Centerboard’s Project Hope to increase access to permanent, safe housing for residents in Lynn and surrounding communities.

Did the hospital hold a meeting open to the public (either independently or in conjunction with its CBAC or a community partner) at least once in the last year to solicit community feedback on its Community Benefits programs? If so, provide the date and location of the event. If not, please explain why not.

- While in-person meetings were hindered in the community, NHC sought creative ways of engaging with our community including:
 - NHC held a public meeting in conjunction with its CBAC on September 14, 2021 to share an overview of the community benefits programs, upcoming CHNA process and goals, and highlights from two community partners on the impact of their programs in FY21. .
 - Conducted quarterly CBAC meetings on December 5, March 26, June 29, and September 14, 2021. In addition, an additional meeting was held on May 13, 2021 to further discuss the upcoming CHNA, and solicit input on how to engage hardly reached populations in the process.
 - Shared information about NHC’s community benefits program process, goals, program highlights, and the FY22 CHNA at meetings throughout its CBSA including:
 - o Gloucester COA, May 4, 2021
 - o Cape Ann Chamber - May 20, 2021
 - o Beverly Diversity Equity and Inclusion Task Force – June 3, 2021
 - o Danvers Town Manager and Board of Health – August 10, 2021
 - o North Shore YMCA – September 8, 2021
 - o Beverly Healthcare Sub Committee, September 15, 2021
 - Ongoing email communication communications with CBAC and Community Partners regarding the Community Health Needs Assessment (CHNA) Engagement Plan and process, and updates.

III. Updates on Regional Collaboration:

1. If the hospital reported on a collaboration in its **Year 1 Hospital Self-Assessment**, please briefly describe any updates to that collaboration, including any progress made and/or challenges encountered in achieving the goals of the collaboration.

NHC is part of the Beth Israel Lahey Health (BILH) system community health planning process. In 2019, BILH formed a system wide Community Benefits Committee (CBC). This Committee provides strategic direction for all 10 BILH hospitals and their affiliates and seeks to ensure that strategies are in place to meet the health care needs of at-risk, underserved, uninsured, and government-payer patient populations in the communities. Guided by the CBC, the hospitals Community Benefits staff meet regularly to review regulatory requirements and share community health programming best practices. Together, hospitals are identifying efficient ways to share information, address health needs, and identify common indicators to measure programmatic impact. All ten hospitals are also now undergoing a Community Health Needs Assessment process collectively.

2. If the hospital entered a regional collaboration in the past year, please provide the information requested of regional collaborations on p. 5 in the **Year 1 Hospital Self-Assessment Form**.
Click or tap here to enter text.