

# Community Benefits Report

## Fiscal Year 2020

Beth Israel Lahey Health   
Beverly Hospital

Beth Israel Lahey Health   
Addison Gilbert Hospital

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## SECTION I: SUMMARY AND MISSION STATEMENT

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### **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). BILH brings together an exceptional array of clinical organizations spanning the continuum of health care delivery – academic and teaching hospitals, community hospitals, ambulatory and urgent care centers, behavioral health programs, and home care – in a shared mission to expand access to great care and to advance the science and practice of medicine through groundbreaking research and education.

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 and behavioral 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. The city of Lynn was a new addition to BH/AGH's CBSA for 2019; while the hospital has limited services in the area, it is open to exploring and supporting collaborative efforts to address priority health needs. 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):

- BH/AGH supported Beverly Bootstraps, which provided home deliveries of groceries to the most vulnerable residents. In FY20, over 2,350 bags of food were delivered to 10 different senior housing sites.
- BH/AGH collaborated with Action, Inc. to support their Welcome Home Program, which provides permanent housing and supportive services to chronically homeless individuals. In FY20, 79% of clients received care from a primary care physician (PCP), 100% of clients attended follow-up appointments or followed through on referrals, and 100% of clients remained in their housing or exited to other permanent housing destinations.
- BH/AGH supported the Lynn Shelter Association in its efforts to effectively connect homeless individuals with job training and career opportunities by supporting the association's Workforce Development Coordinator. Employment and workforce development resources were made available to 64 heads of household in family shelters with 22 engaging more deeply in referrals and resources.
- Provided 3,262 free breast Cancer Risk Assessment (CRA) screenings to persons who may have a higher lifetime risk of developing breast cancer, and provided screening follow-up to their physicians.
- Connecting Young Moms (CYM) programs offered comprehensive pre- and postnatal programs to young mothers and their children. CYM offered five childbirth-preparation series over the course of the year, including one group that was fully remote in order to comply with COVID-19 distancing guidelines.
- The Compass Moms Do Care Program provided support for pregnant and parenting women with a history of substance use. The COVID-19 pandemic led to suspension of in-person groups and in-person behavioral health services. As a result, the program supported women through "porch visits," grocery runs, formula, and diaper assistance, and ongoing individual work.
- In FY20, the Gloucester School Based Health Center provided 719 nurse practitioner visits, 707 social worker visits, and 2,873 total assessments. Staff organized 21 outreach activities including social skills work groups and reproductive health classes. The center pivoted to meet the needs of students during the pandemic and worked to establish the Free Food Locker for students in need.
- In FY20, the Mobile Phlebotomy Team from BH/AGH Laboratory scheduled and performed approximately 5,411 free homebound lab visits. In addition to patients and families appreciating the convenience of the home blood draws, patients have reported reduced feelings of isolation because the visit with the phlebotomist provided them with a social opportunity.

- In FY20, the Oncology Nurse Navigators at BH/AGH supported 823 new patients by connecting patients with resources, including health care and support services, in their communities and assisting them in the transition from active treatment to survivorship.
- BH/AGH partnered with the North Shore YMCA to offer free Enhance Fitness classes in the community. From October 2019 to September 2020, 249 participants were reached in the traditional setting – in person at the Y or at a community-based location.
- In FY20, BH/AGH continued to meet the health care needs of patients and responded to 59,500 inquiries to the Patient Financial Counseling office. These included patients 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.
- In FY20, BH/AGH collected and disposed of 1,400 pounds of medications, which was a 40% increase over medication collected and discarded in FY19.
- Wellspring provided adult education, job training, and career advising and mentoring to 442 young adults and adults throughout the North Shore region in FY20.

For the FY20 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. In some cases, programs were expanded. In others, programs were cut or significantly reduced because of the pandemic.

### **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.

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## SECTION II: COMMUNITY BENEFITS PROCESS

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### **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 Strategy 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 Strategy 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 – Chairwoman, Northeast Hospital Corporation Board of Trustees

Phil Cormier – President, Northeast Hospital Corporation

Robert Irwin – Trustee, Northeast Hospital Corporation

Mark Gendreau, MD – Chief Medical Officer, Addison Gilbert and Beverly Hospitals

Craig Williams – Chief Operating Officer, Addison Gilbert and Beverly Hospitals

Peter Short, MD – Associate Chief Medical Officer, Addison Gilbert and Beverly Hospitals

David DiChiara, MD – Associate Chief Medical Officer, Addison Gilbert and Beverly Hospitals

Kimberly Perryman – Chief Nursing Officer, Addison Gilbert and Beverly Hospitals

Cynthia Donaldson – Vice President, Addison Gilbert Hospital and Lahey Outpatient Center Danvers  
Christine Healey – Director, Community Relations, Beth Israel Lahey Health  
Grace Numerosi – Regional Manager, Community Relations, Addison Gilbert and Beverly Hospitals  
Chessye Moseley – Resident  
Christopher Lovasco – President and CEO, North Shore YMCA  
Julie LaFontaine – President & CEO, The Open Door  
Scott Trenti – Executive Director, SeniorCare  
Andrew DeFranza, Harborlights Community Partners

### **CBAC Meetings:**

The CBAC met four times in FY20 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 24, 2020

### **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 with which BH/AGH joins in assessing community need as well as planning, implementing, and overseeing its Community Benefits 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
- Danvers Rotary
- Danvers YMCA
- Gloucester School Dept.
- The Grace Center
- North Shore Elder Services
- 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

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## SECTION III: COMMUNITY HEALTH NEEDS ASSESSMENT

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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 commonwealth 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 Winchester Hospital. BH/AGH works 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 and access to care:** The **social determinants of health** (e.g., 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 the social determinants of health have on residents of BH/AGH's service area, especially those who have low-to-moderate income, are frail or homebound, have mental health or substance use issues, or lack a close support system.

Certain populations are more **vulnerable to health care disparities and barriers to care**. 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 low-income, Medicaid-covered, uninsured, and otherwise vulnerable 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, especially 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.
- 4) **Chronic Disease: Chronic diseases** (e.g., cardiovascular disease, cancer, diabetes, asthma) require more education, screening/early intervention, and management – and a focus on risk factors. Although there was major emphasis on behavioral health issues, many key informants, focus group participants, and listening session participants identified a need to address the many risk factors associated with chronic and complex health conditions. Physical inactivity and poor nutrition/lifestyle were discussed by many – some of these issues being associated with age (mobility issues among older adults), education/health literacy (lack of understanding about healthy eating), and socioeconomic status (fresh foods being more expensive, gyms and health centers unaffordable). Addressing the leading risk factors is at the root of many chronic disease prevention and management strategies.

#### **Priority Populations:**

All segments of the population face challenges that may limit their ability to access health services, regardless of age, race/ethnicity, income, family history, or health status. The body of this report includes a comprehensive review of the full breadth of quantitative and qualitative data compiled as part of this assessment effort; this review includes findings that touch on common challenges cited among community residents throughout the service area. In order to target community benefits efforts and to comply with commonwealth and federal guidelines, there was an effort to prioritize segments of the population with complex health needs or who face significant barriers to care.

With this in mind, four population segments were prioritized: older adults, children and families, individuals and families of low resources, and individuals with chronic/complex conditions.



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## SECTION IV: COMMUNITY BENEFITS PROGRAMS

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### Priority Area #1: Social Determinants of Health & Access to Care

#### *Beverly Bootstraps Mobile Market*

**Description:** Pre-pandemic, a Senior Mobile Market was offered all year long at the Beverly Senior Center. The purpose was to bring a free, fresh, traveling farmers market to our Beverly Housing clients and seniors at the Beverly Council on Aging. Once COVID-19 hit, we were unable to operate this and most other programs. The elderly were and remain the most vulnerable at this time. Visiting a grocery store or food pantry is not an option for many. The only way for low-income individuals to access food is through food assistance and delivery. In response, from March 30 through September 30, we started to deliver food to some of the seniors residing in low-income housing in Beverly. The goal was to provide food to low-income seniors who may not have the means to get to the grocery store, Beverly Bootstraps' Food Pantry, or community meal sites. This also ensured that this population did not risk traveling outside their home to access essential food.

**Goal:** To provide a free fresh traveling farmers market to our Beverly Housing clients and seniors during the summer and fall of 2020

**Goal Status:** 44 deliveries were made to senior sites. Delivered 2,351 bags of food to ten different senior housing sites reaching a total of 520 unique individuals representing 515 households

#### *Connecting Young Moms*

**Description:** Connecting Young Moms (CYM) program offers comprehensive pre- and postnatal programs to young mothers and their children. For many, the program offers a lifeline at this pivotal time in their lives. CYM is offered at no cost by the Beverly Hospital Social Work Department in collaboration with the Parent Education Department. CYM serves young mothers and mothers-to-be who have limited resources and often have little emotional and social support. The prenatal component of the CYM program is the Childbirth Preparation Series. This program is specifically for teens and young women and their support people. The series is 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. We also continue to provide services to mothers who have "graduated" from active group participation.

**Goal:** Through a team approach, staff will commit to bringing health and parenting education, community resources, and peer support to help young mothers develop healthy and positive parenting skills.

**Goal Status:** Connecting Young Moms offered 5 childbirth preparation series over the course of the year: one standard and four shortened. In addition, we serviced one group fully remote in order to comply with COVID-19 distancing guidelines. In total, our prenatal preparation program serviced 22 young mothers plus 19 fathers/support people. CYM offered in-person postpartum support groups until mid-March to our core group of 16 young mothers and their 21 children. We have been providing our services virtually since then. Those services also include working with referrals to connect with community resources. CYM processed an additional 36 referrals and provided resource and referral efforts.

#### *Senior Dine & Learn*

**Description:** Age is a fundamental factor to consider when assessing individual and community health status. Older individuals typically have more physical and mental health vulnerabilities and are more likely to rely on immediate community resources for support than are young people. The percentage of the population over 65 is high or significantly high in all municipalities in our service area compared to the commonwealth. The percentage of the population over 85 is significantly higher in Gloucester, Beverly, and Danvers. Key informants and focus group/forum participants in the BH/AGH CHNA expressed concern about social isolation and depression among older adults, especially frail elders who live alone or who do not have a regular caregiver.

To address these issues, BH/AGH, in partnership with Unidine and local Councils on Aging, hosts a monthly senior meals program. The program works to keep local senior citizens healthy and safe by hosting free education seminars on health and personal safety while providing a hot, healthy, and nutritious meal in a community setting that allows for social engagement and interaction.

**Goal:** In FY20, BH/AGH will conduct monthly health education sessions serving the elderly population.

**Goal Status:** In FY20, BH/AGH conducted two sessions serving over 240 elder adults.

### **Welcome Home Program**

**Description:** The Welcome Home 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. Housing First is an evidence-based model that was created with a simple belief that people cannot successfully manage their health within the instability of homelessness. Housing First programs believe that housing is a human right and a critical health intervention. Housing First believes people should be given an apartment first so they have a stable place to live and from which they can more successfully work on maintaining sobriety, gaining employment, and improving their health. A Senior Mobile Market was offered all year long at the Beverly Senior Center. The purpose was to bring a free, fresh, traveling farmers market to our Beverly Housing clients and seniors at the Beverly Council on Aging. Once COVID-19 hit, we were unable to operate this and most other programs. The elderly were and remain the most vulnerable at this time. Visiting a grocery store or food pantry is not an option for many. The only way for low-income individuals to access food is through food assistance and delivery. In response, from March 30 through September 30, we started to deliver food to some of the seniors residing in low-income housing in Beverly. The goal was to provide food to low-income seniors who may not have the means to get to the grocery store, Beverly Bootstraps' Food Pantry, or community meal sites. This also ensured that this population did not risk traveling outside their home to access essential food.

**Goal:** The goals of the Welcome Home Program are 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.

**Goal Status:** In FY20, 79% of clients received care from a PCP, 100% of clients attended follow-up appointments or followed through on referrals from a PCP, emergency department usage decreased by 45% among our clients, and 100% of clients remained in their housing or exited to other permanent housing destinations.

### **City of Beverly Summer Literacy Program**

**Description:** The Summer Literacy Program was designed to provide summer 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, provides a six-week, no-cost summer learning program to approximately 180 children entering first, second, and third grade. The day camp will include three hours of literacy instruction in the morning and a traditional summer camp experience in the afternoon. Children receive literacy instruction including spelling, grammar, vocabulary, self-selected reading, and small-group guided reading. Afternoon programming at Sterling YMCA includes enrichment activities such as arts and crafts, music, team-building activities, swimming, and much more.

**Goal:** The goals of the program are twofold: do everything in our power to help all kids achieve grade-level literacy, and provide a summer camp opportunity to help these children grow healthy and happy.

**Goal Status:** In FY20, 100% of participating students maintained or improved their literacy foundational skills, and over 75% of students made ambitious gains in their early literacy skills

### **Lynn Shelter Connecting Homeless to Workforce Development Opportunities**

**Description:** The Lynn Shelter Association connects homeless individuals with job training and career services by funding a half-time Workforce Development Coordinator/Job Coach to serve as our in-house liaison with MassHire. The coordinator works with case managers to educate clients about programs and eligibility, run workshops for clients in-house, and work one-on-one with clients to support them in resume writing, interviewing skills, and accessing all available resources with the goal to support them in advancing their ability to earn a living wage.

**Goal:** To connect homeless clients to workforce development opportunities.

**Goal Status:** Employment and workforce development resources were made available to all 64 heads of household in family shelters (3 sites), with 22 engaging more deeply in referrals and resources and following up with exploring program opportunities (March 2020 – Sept. 2020). In addition:

- 1 client participated in a Roots Culinary training program.
- 2 are currently enrolled in a Medialerk training program, and 2 completed that training.
- 2 participated in the Triangle, Inc. workshops/trainings (culinary).
- 6 participated in ESOL trainings/workshops.
- 2 participated in GED/HiSET workshops/training.
- 3 clients secured jobs as CNAs and 1 as a cook at My Brother's Table, with additional clients securing employment via their own resources in combination with those provided by the employment specialist.
- 3 clients referred to Northeast Legal Aid for CORI education/petition to seal as a result of being denied employment opportunity due to CORI.
- 4 clients referred to MassHire to begin trainings/workshops, which they began, but programs were suspended due to COVID-19.

### **Patient Financial Counseling**

**Description:** The extent to which a person has health insurance that covers or offsets the cost of medical services, coupled with access to a full continuum of high-quality, timely, accessible health care services, has been shown to be critical to overall health and well-being. Access to a routine source of primary care is particularly important because it greatly impacts a person's ability to receive preventive, routine, and urgent care as well as chronic disease management services. Despite the overall success of the commonwealth's health reform efforts, information captured for this assessment shows that while the vast majority of the area's residents have access to care, significant segments of the population, particularly low-income and racial/ethnic minority populations, face significant barriers to care. These groups struggle to access services due to lack of insurance, cost, lack of transportation, cultural/linguistic barriers, and a shortage of providers willing to serve Medicaid-insured or uninsured patients. To address these gaps, NHC employs six MassHealth-certified Application Counselors who can screen patients and assist them in applying for state aid. They also estimate for patients their financial responsibility (copay, deductible, coinsurance, self-pay). Financial Counselors spend their time helping patients with issues related to financial assistance and estimates and helping patients understand their insurance benefits.

**Goal:** To meet with patients who are uninsured to assess their eligibility for and align them with state financial assistance and hospital-based financial assistance programs.

**Goal Status:** Financial Counselors met with patients (both inpatient and outpatient) and completed 5,641 MassHealth applications. NHC had over 59,500 patient visits in FY20. These included patients 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. The age ranges of patients and the percentage of patients within each age range were:

- |                     |                     |
|---------------------|---------------------|
| • 0-17 years (22%)  | • 36-53 years (26%) |
| • 18-35 years (32%) | • 54-71 years (19%) |
|                     | • 72-107 years (1%) |

Based on the data reviewed, the employment status obtained at time of service was:

- |  |                  |
|--|------------------|
| • 10,630 employed full time or part time | • 1,675 retired  |
| • 12,160 unemployed                      | • 2,425 disabled |
| • 2,130 self-employed                    |                  |

### **Interpreter Services**

**Description:** An extensive body of research illustrates the health disparities and differences in health care access and utilization that exist for diverse individuals/cohorts and foreign-born populations. According to the CDC, non-Hispanic blacks have higher rates of premature death, infant mortality, and preventable hospitalization than do non-Hispanic whites. Hispanics have the highest uninsured rates of any racial or ethnic group in the United States. Asians are at a higher risk for developing diabetes than are those of European ancestry, despite a lower average body mass index. These disparities show the disproportionate and often avoidable inequities that exist within communities and reinforce the importance of understanding the demographic makeup of a community to identify populations more likely to experience adverse health outcomes. The NHC service area is quite diverse with significant populations of Asian and Hispanic/Latino residents throughout the service area. Language barriers pose significant challenges to providing effective and high-quality health and social services. To address this need, and in recognition that language and cultural barriers are major 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.

**Goal:** To provide culturally responsive care through Interpreter Services Department.

**Goal Status:** In FY20, NHC interpreters reported 9,658 encounters at Beverly Hospital and 763 encounters at Addison Gilbert Hospital.

### **Backyard Growers**

**Description:** School, community, and backyard gardens are a critical part of our local food system – especially during a crisis. When the pandemic struck, the City of Gloucester categorized Backyard Growers as an essential service because of our food access and food security mission. In the spring, our small staff and volunteer team responded swiftly and decisively to serve our participants and launch the growing season while managing competing disruptions and an increase in demand. We partnered with the City Health Department and Gloucester Housing Authority to safely open all community garden sites and to construct an increased number of new backyard gardens for low-income families and older adults, helping to improve healthy food access and security for hundreds of Gloucester residents. We worked with Action homeless shelter and The Open Door food pantry to open their gardens and operate safe food production to provide fresh food for their community meals and pantry distribution.

**Goal:** To provide the community with tools to grow their own produce at home

**Goal Status:** Fulfilled a total of 330 free and discounted supply orders, representing over 2,400 units of seed packets, seedlings, bagged compost, and grow bags, primarily through two daylong curbside pick-up events and three delivery days. Also distributed Salad Days growing kits to 100% of second graders (over 200 students) to grow food at home as part of their science curriculum, and made an online tutorial to teach children how to assemble their kits. Kits included a grow bag, soil mix, lettuce seeds, and kid-friendly assembly, planting, and care directions.

### **Wellspring House “Clinical Supports for Workforce Development” Program**

**Description:** The Wellspring House “Clinical Supports for Workforce Development” program aims to widen access to quality mental health services for low-income adults between the ages of 18 and 55 who participate in Wellspring’s education, job training, and career advising programs. Those who display signs and symptoms of mental health concerns will be referred to an in-house licensed clinician for screening. This added support increases the percentage of students who complete programs and reach concrete educational and employment milestones.

**Goal:** To provide clinical supports for Workforce Development.

**Goal Status:** Wellspring provided adult education, job training and career advising and mentoring to 442 young adults and adults throughout the North Shore region in FY20.

### **The Open Door “Food is Medicine (Rx)” Program**

**Description:** The Registered Dietitian (RD) for the Food Is Medicine (Rx) program supports the organizational goals and mission of The Open Door to alleviate the impact of hunger in our communities. They use practical strategies to connect people to good food, to advocate on behalf of those in need, and to engage others in the work of building food security. There are many challenges people with food insecurity face when living with a chronic illness, including not understanding that food is a vital component to wellness and lack of access to nutritious foods. The RD for Rx program was designed to address these issues. The Open Door’s Registered Dietitian works to ensure that low-income, food-insecure people struggling with or at risk of chronic illness will have access to free nutrition services.

Services included Maridee’s (Good Food Box) Community Nutrition Workshops, nutrition counseling, and hosting of nutrition interns. The Registered Dietitian (RD) for the Food Is Medicine (Rx) program supports the organizational goals and mission of The Open Door to alleviate the impact of hunger in our communities. They use practical strategies to connect people to good food, to advocate on behalf of those in need, and to engage others in the work of building food security. There are many challenges people with food insecurity face when living with a chronic illness, including not understanding that food is a vital component to wellness and lack of access to nutritious foods. The RD for Rx program was designed to address these issues. The Open Door’s Registered Dietitian works to ensure that low-income, food-insecure people struggling with or at risk of chronic illness will have access to free nutrition services.

<u>Goal</u>	<u>Goal Status</u>
RD to complete at least 40 counseling sessions for at least 15 clients.	<p>Because of COVID-19, counseling was suspended from mid-March to June. In FY20 59 counseling sessions were completed for 21 clients with various chronic health conditions with the following results.</p> <p>83% Learned something new  83% Have been making healthier choices  67% Better equipped to manage chronic health conditions  92% Able to read nutrition label  100% Know how to shop for healthy food</p>
Provide at least 16 Community Maridee's Nutrition workshops (senior/co-generation/family)	<p>Despite COVID-19 ending workshops in mid-March, completed 14 Community Workshops: 5 senior workshops impacting 51 seniors; 9 family workshops impacting 89 participants.</p> <p>93% Learned something new  93% Will make healthier choices  93% Would attend another workshop  90% Would refer a friend to a workshop</p>
Provide nutrition education classes called "Dish" to girls at O'Malley Innovation Middle School to promote health, wellness, and body positivity.	<p>Despite COVID-19 closing the school mid-March (preventing the third session), TOD provided 2 sessions of 8 classes per session (total 16 classes) for 22 and 18 teenage girls (total 40 girls).</p> <p>88.9% Liked Dish  77.8% Learned something new  44.4% Learned to read a nutrition label</p>
Manage Maridee's Nutrition Interns including RD and public health practicums.	<p>Goal was to manage at least 6 Nutrition Interns.</p> <p>Our RD managed 7 interns: 2 from University of New England, 2 from U Mass Lowell, 2 from Simmons University, a Dietetic Intern from Wellness Workdays.</p>
Plan, enroll and implement Medically Tailored Grocery (MTG) Program	<p>Goal partially met. Curriculum completed, partners secured, referrals and clients registered and completed in March. However, mid-March MTG suspended due to COVID-19. Pilot launched successfully in Oct. 2020 –beyond this grant's timeline.</p>
Connect people to good food.	<p>Goal met and exceeded: Provided 9,585 unduplicated people with 1,954,401 meals (or 2,345,281 pounds of food), representing 4,468 households. Requests for food assistance were up 27% over last year.</p> <p>Our food pantry qualitative surveys were completed in March 2020 – are not reflective of the COVID-19 period of increased need. However, qualitative surveys showed:</p> <p>81.09% Choose healthier options  80.83% Eat more family meals at home now  77.2% Eat healthier when they shop at pantry  75.39% Eat more fruits and vegetables  40.16% Try TOD recipes at home</p>

### **Serving the Health Information Needs of Everyone (SHINE)**

**Description:** 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. Health insurance makes a difference when it comes to individuals receiving medical care, where they get this care, and ultimately how healthy they are. People without adequate insurance are much more likely to postpone preventive care, health screenings, and necessary treatment. The cost of putting off needed medical care, not filling prescribed medications, and skipping routine exams can be severe, particularly when preventable or treatable diseases go undetected. While there are public health safety nets offered by nonprofit hospitals and community health centers, these programs do not close the health insurance gap for those who are completely uninsured. SHINE counselors help Medicare beneficiaries understand what they need for insurance coverage based on medical history, current health, and prescribed medication(s), along with costs incurred by not having supplemental insurance. A one-hour visit with a SHINE counselor can save a consumer thousands of dollars in out-of-pocket costs by comparing plans through a newly designed Medicare plan-finder tool. Counselors also have access to proprietary information developed by the Executive Office of Elder Affairs, Center for Medicare & Medicaid Services, and the Massachusetts Department of Health and Human Services, referred to as Common Resources, a password-protected intranet for counselors. SHINE counselors are part accountant, part software specialist, part researcher, part nurse, part pharmacist, part social worker, and part advocate, often seeing consumers yearly for a “health insurance checkup.” 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.

**Goal:** Every week, a trained SHINE liaison is available at the Beverly Council on Aging and both Beverly and Addison Gilbert Hospitals 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 FY20, SHINE counselors conducted 3,226 visits throughout the North Shore and Cape Ann; 3,058 by Shine Hospital Staff and 168 by Shine Volunteer.

## **Priority Area #2 - Chronic and Complex Conditions and Risk Factors**

### **Breast Cancer Risk Assessment**

**Description:** In the BH/AGH service area, eight of the 13 towns that are part of our primary service area reported statistically higher incidence rates of cancer (all cancer types) than the average in the commonwealth. These rates compare to 509 for the commonwealth and 531 for Essex County. Specifically, breast cancer hospitalization rates for women were statistically higher than the commonwealth’s rate across nearly all the primary service area’s cities/towns. The risk for breast cancer is not the same for all women, and some women need more advanced screening beyond the standard recommendations. In response to this identified community need, NHC has implemented an assessment screening tool to help community residents determine whether they may be at risk for breast cancer. Using an electronic tablet, people are able to confidentially answer questions that help determine whether they may be at higher risk for breast cancer. The assessment, evaluation, and follow-up are all provided at no cost to the participant. Results are given to their physician, who can help them determine whether they might benefit from a higher level of screening beyond regular checkups and mammograms.

**Goal:** The goal of providing the breast CRA screening is to identify persons who may be at a higher lifetime risk for developing breast cancer and provide screening follow-up to their physicians.

**Goal Status:** In FY20, In FY20, NHC conducted 3,262 free screenings identifying 312 patients with a high lifetime risk for breast cancer.

### **Home Blood Draw Program**

**Description:** The BH/AGH Laboratory Homebound Phlebotomy Program was developed to enhance access to laboratory services for homebound patients who have difficulty getting to a specimen collection station. Homebound Phlebotomy services are provided as a courtesy to patients and physicians of BILH. Homebound patients are defined as individuals with a condition due to surgery, illness, or injury that precludes them from accessing medical care outside their home, as well as patients who experience a considerable and taxing effort to leave the home, and/or require the assistance of a device, other persons, or special transportation.

**Goal:** To 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 FY20, the Mobile Phlebotomy Team from BH/AGH Laboratory scheduled and performed approximately 5,411 free homebound lab visits. Patients have reported reduced feelings of isolation because the visit with the phlebotomist provided them with a social opportunity

### **School Based Health Center at Gloucester High School**

**Description:** BH/AGH believes that everyone deserves high-quality, affordable health care and strives to promote health, expand access, and deliver the best care in the communities it serves. BH/AGH dedicates resources to support and strengthen the capacity of the primary care offices to help community members connect with and access timely, safe, quality patient care. 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. While Massachusetts has one of the highest health insurance coverage rates in the U.S., there are still pockets of individuals without coverage, including young people, immigrants and refugees, and those who are unemployed. In Gloucester, 3% of the city's population have no insurance and 40.2% receive public insurance (e.g., MassHealth, Medicare).

The mission of the School-Based Health Center (SBHC) is to provide high-quality, comprehensive health care to students 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 the Massachusetts DPH. The mission of the SBHC aligns closely with the priorities identified by Addison Gilbert in its most recent Community Health Assessment. Our recent CHNA of youth health needs and youth focus groups showed that youth were most concerned about chronic stress/anxiety, depression, and suicidality. The SBHC joins with existing school services to provide comprehensive in-school health care that is easily accessible to students. The approach is to take care of the students' health and well-being while supporting attendance and achievement of academic success. 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 any personal health issues they have questions about. For example, the SBHC improves access to behavioral health and substance abuse services by offering these services on-site, and integrates those services into primary medical care. The SBHC also identifies students with chronic conditions and helps them improve self-management of these conditions. Whether an individual has health insurance – and the extent to which it helps pay for needed acute services and access to a full continuum of high-quality, timely, and accessible preventive and disease management or follow-up services – is a critical determinant of overall health and well-being.

The SBHC is staffed by a Nurse Practitioner, a Licensed Independent Clinical Social Worker, and a Certified Community Health Worker. The SBHC provides an integrated model of care in its approach. Services offered 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. As evidenced by its staffing structure, behavioral health care is a significant focus of the clinic, with individual therapy and group counseling services provided for issues such as depression, anxiety, stress management, and substance use.

**Goal:** To provide high-quality comprehensive health care to students to support optimal health and academic outcomes.

**Goal Status:** The clinic had 719 nurse practitioner visits, 707 social worker visits, and 2,873 total assessments. Staff organized 21 outreach activities including social skills work groups and reproductive health classes. The NP and LICSW work both in person and via telehealth for clinical visits. They also facilitate and mentor the GHS-SBHC Youth Advisory Council (YAC). Meetings continued online during COVID-19 as a means to keep connected to students during April, May, and June. Another public health initiative run by the GHS-SBHC is the Walking Club that is available to students multiple times a week to encourage student exercise, instill healthy life choices, and discuss topics important to teens. Gym credit is granted for the Walking Club, providing another means for students to earn enough gym credits to graduate. Students met weekly in a remote capacity during April through the end of July 2020 and resumed in person for the new school year in September 2020. In December 2019, the GHS-SBHC initiated a new collaborative between itself, GHS, and The Open Door food pantry. This new collaborative is called the Free Food Locker (FFL), a shelf pantry that is available for all GHS students to take food home to their families.



### **Oncology Nurse Navigator**

**Description:** 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.

**Goal:** 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

**Goal Status:** In FY20 the Oncology Nurse Navigators at BH and AGH supported 823 new patients in the practice, in addition to the ongoing support of existing patients and their families/caregivers under care of the hematology-oncology provider

### **Healthy State Web Based Health News**

**Description:** More people are turning to web-based resources for health information. By providing expert health information, personal stories, and connections to resources, Healthy State provides health information to educate and influence people to change their unhealthy behaviors and encourage interventions capable of improving health status. We collaborate with practitioners (doctors, advanced practitioners, staff, etc.) on stories across various service lines in order to share information relevant to our audience.

The site, <https://www.myhealthystate.org>, offers free, easy-to-read articles for the community.

The site provides health news, living-well tips, and real stories to engage the community. Topics include:

- Cancer awareness, including the benefits of cancer screenings and information on breast, skin, colon, cervical, prostate, and lung cancers.
- Sports and exercise safety, healthful eating, high blood pressure, and heart health.
- Seasonal wellness tips, including healthy holiday eating tips, differences between the cold and flu, and water safety.
- Child health including information related to ADHD, febrile seizures, and asthma.

**Goal:** Healthy State seeks to influence personal health choices, to inform people about ways to enhance health or to help them avoid specific health risks by increasing knowledge and awareness of health issues; to influence behaviors and attitudes toward a health issue; and to dispel misconceptions about health.

**Goal Status:** In FY20 there were 72,205 page views, 8,700 return users, and an average of 1.14 seconds per session.

### **Support Groups**

**Description:** NHC offers a variety of monthly support groups for patients dealing with various diseases, conditions, and concerns to help inform, console, and lift the spirits of participants:

- Diabetes Support Group
- Gloucester Stroke Club
- Melanoma Support Group
- Huntington's Disease Support Group
- Prostate Cancer Support Group
- Surgical Weight Loss Support Group
- Cardiac Rehab Support Group

**Goal:** To provide emotional support to patients during difficult times, and to provide education about available community resources.

**Goal Status:** In FY20, NHC conducted support groups for different diseases/conditions/concerns.

### **YMCA Corner Stone Program**

**Description:** Corner Stone is a collaborative health and wellness program providing essential daily living support to cancer patients, cancer survivors, and their immediate families. The YMCA of the North Shore provides these families

with a complimentary one-year, full-privilege membership as well as specialized education and peer support opportunities. Participants receive a free one-year membership for them and their immediate family. They are able to use everything the Y has available (fitness floor/classes, pool, gym/basketball, gymnastics, child care) as often as they like, at their convenience, as well as participate in all family and educational events.

**Goal:** To enroll 1,500 members into the program in the first year

**Goal Status:** The total number of members in the Corner Stone program was 2,134; the total utilization (number of scans into the facility) was 9,999; thus, the average usage per Corner Stone member was 4.7 visits (4.7 scans per member).

## Priority Area #3 – Substance Dependency

### Medication Disposal Boxes

**Description:** Beverly Hospital provides a medication disposal kiosk to safely dispose of expired or unwanted medication. Medications can be dropped off 24 hours a day, seven days a week in the Emergency Room Waiting Area and are safely disposed of in accordance with Drug Enforcement Administration regulations. According to the National Institute on Drug Abuse (NIDA), an estimated 54 million people have used medications for nonmedical reasons at least once in their lifetime. Opioids are among the most misused prescriptions, with 75% of those who abuse them reporting their first opioid was a prescription.

**Goal:** To provide a safe and convenient way for residents to dispose of unwanted or unused medications.

**Goal Status:** In FY20, Beverly Hospital collected and disposed of 1,400 pounds of medications, which was a 40% increase over medication collected and discarded in FY19.

### High Risk Intervention – SHIFT Care Model

**Description:** The SHIFT Care Grant from the Health Policy Commission made it possible for Beverly Hospital and Addison Gilbert Hospital to provide medication for opiate use disorder (MOUD) to eligible patients in the Emergency Department (ED). ED Medical Providers can dispense buprenorphine to patients that enter the ED and are identified to have an opioid use disorder (OUD). With this grant the primary aim of the LEAP to Recovery Initiative is to identify persons with opioid use disorder (OUD) who present in our EDs and compare the effectiveness of a MAT induction and follow-up MAT management among those who accept MAT versus those who opt not to participate in MAT. AGH and BH targeted patients with OUD who were willing to initiate MAT for treatment of opioid use disorder. These patients were either given a 3 day supply of Suboxone in the ED or referred directly to our partner, BILHBS, for induction in their OBOT clinic. Patients not willing to initiate MAT were enrolled and referred to alternate treatment options. Patients also received a naloxone (NARCAN) prescription and information on obtaining the medication free of cost through DPH pilot sites. The SHIFT Care team consisted of a Physician Assistant, Recovery Coaches, clinic services for ongoing treatment with our partner BILHBS. Included in the initiative was training the nursing on the Clinical Opioid Withdrawal Scale tool to

**Goal:** The primary aim of the LEAP to Recovery Initiative is to identify persons with opioid use disorder (OUD) who present in our EDs and evaluate the effectiveness of MAT induction and follow-up MAT management among those who accept MAT

**Goal Status:** The SHIFT Care grant served 580 patients and initiated 100 patients on MAT  
60-70% of those who initiated on MAT were still engaged at 30 days

### Compass “Moms do Care” Program

**Description:** The Moms do Care Program provides support for pregnant and parenting women with a history of substance use. The program offers prenatal and postnatal medical care, medication-assisted treatment for addiction, “peer mom” recovery coaches, a team lead social worker (LCSW) for case management, and a mental health counselor to provide weekly support groups and therapy as well as recovery support. The overall program goals are to promote recovery in pregnant and parenting women, improve perinatal care of the mother-baby dyad, and improve dyadic outcomes. We aim to achieve these goals through a multidisciplinary approach focused on improved maternal substance use treatment, trauma-informed and evidence-based maternal and neonatal care, and increased support for substance-exposed newborns and their families. A key element of Compass is its structured support groups made up of other women in the program and “graduates” who continue to work on their sobriety as mothers of young children.

The COVID-19 pandemic led to suspension of in-person groups and in-person behavioral health services in the Lahey System, and contributed to food and housing insecurity among our clients. In the early days of the pandemic, we supported women through “porch visits,” grocery runs, formula, and diaper assistance, and ongoing individual work. We moved groups to an online format and added additional coping skills and parenting groups. We continue with ongoing assistance with food, formula, and baby items.

**Goal:** For pregnant women, the goals are sufficient prenatal and postnatal care, recovery without substance use, and referral for behavioral health services and hepatitis C treatment (if applicable). For their infants, our goals are reduced length of stay for treatment of NA, discharge in maternal custody, and early intervention referral.

**Goal Status:** To date, the program has served over 115 moms. Currently there are 40 women engaged in services. Clients enrolled in the program were more likely to initiate prenatal care in the first trimester, attend a postpartum visit, and initiate postpartum contraception. They were discharged from the hospital with the baby in their custody 73% of the time.

## Priority Area #4 – Mental Health

### Collaborative Care Model

**Description:** The National Alliance on Mental Illness (NAMI) reports one in four individuals experience a mental illness each year, underscoring a critical need for mental health care access across all patient populations. In the 2019 BH/AGH CHNA, mental health was identified as one of the leading health issues for residents of the service area. Further, individuals from across the health service spectrum discussed the burden of mental health issues for all segments of the population, specifically the prevalence of depression and anxiety. BILH Behavioral Services (BILHBS) provides individual and group therapy for mental health and substance use issues; additional treatment; family services; mobile crisis teams for behavioral health and substance-related emergencies; inpatient psychiatric care, plus home- and school-based programs for children and teens. This past year, BILHBS in collaboration with Lahey Health Primary Care expanded the Collaborative Care Model (CoCM) to additional communities throughout the BILH service area. CoCM is a nationally recognized primary care–led program that specializes in providing behavioral health services in the primary care setting. The services are provided by a licensed behavioral health clinician and include counseling sessions, phone consultations with a psychiatrist, and coordination and follow-up care. The behavioral health clinician works closely with the primary care provider in an integrative team approach to treat a variety of medical and mental health conditions. The primary care provider and the behavioral health clinician develop a treatment plan that is specific to the patient’s personal goals. The behavioral health clinician uses therapies that are proven to work in primary care. A consulting psychiatrist may advise the primary care provider on medications that may be helpful. FY19 successes included hiring and training behavioral health clinicians.

**Goal:** To increase access to mental health services by expanding the CoCM model to additional communities throughout the BILH service area.

**Goal Status:** Served 10 primary care practices, reaching 1,747 patients.

## SECTION V: EXPENDITURES

Item/Description	FY20 Amount	FY20 Amount Provided to Community Organizations
Direct Clinical Services	\$8,981,964.15	\$75,755.00
Community-Clinical Linkages	\$73,689.48	\$45,000.00
<b>Total Population/Community Wide Interventions</b>	<b>\$367,573.43</b>	<b>\$177,770.00</b>
Access/Coverage Supports	\$1,816,392.54	\$122,589.00
Infrastructure to Support CB Collaborations	\$237,452.00	\$0.00
<b>Total by Program Type</b>	<b>\$11,477,071.60</b>	<b>\$421,114.00</b>
Chronic Disease	\$7,416,754.10	
Mental Health/Mental Illness	\$2,662,612.49	
Substance Use Disorders	\$91,593.45	
Housing Stability/Homelessness	\$119,363.00	
Additional Health Needs	\$1,186,748.56	
<b>Total by Health Need</b>	<b>\$11,477,071.60</b>	
Leveraged Resources	\$1,457,092.60	
<b>Total Direct CB Programming</b>	<b>\$12,934,164.20</b>	
HSN Assessment	\$1,929,027.00	
HSN Denied Claims	\$641,343.00	
Free/Discount Care	\$0.00	
<b>Total Net Charity Care</b>	<b>\$2,570,370.00</b>	
<b>Total CB Expenditures (Includes Programs, Leveraged, and Charity Care)</b>	<b>\$15,504,534.20</b>	
Net Patient Services Revenue	\$385,162,220.00	
CB Expenditure as % of Net Patient Services Revenue	<b>4.03%</b>	
Bad Debt (Optional)	\$2,794,552.00	