Northeast Hospital Corporation
Beverly Hospital and Addison Gilbert Hospital
Implementation Strategy 2020–2022

Between November 2018 and August 2019, Beverly Hospital and Addison Gilbert Hospital (BH-AGH) conducted a comprehensive Community Health Needs Assessment (CHNA) that included an extensive review of existing quantitative data as well as the collection of qualitative information through interviews, focus groups, community listening sessions, and a community health survey. A resource inventory was also completed to identify existing health-related assets and service gaps. This extensive array of assessment and community engagement activities allowed BH-AGH to collaborate with key health system partners across the region. During the CHNA process, BH-AGH also made substantial efforts to engage their own administrative and clinical staff, including senior leadership. A detailed review of the CHNA approach, data collection methods, and community engagement activities is included in BH-AGH's 2019 Community Health Needs Assessment report.

Throughout the CHNA process, BH-AGH's Community Relations staff worked with the Hospitals' Community Benefits Advisory Committee (CBAC), composed of senior leadership from the Hospitals and community stakeholders/service providers, to:

- Describe quantitative and qualitative findings
- Prioritize community health issues and vulnerable populations
- Review existing community benefits programming
- Develop BH-AGH's 2020–2022 Implementation Strategy

IMPLEMENTATION STRATEGY PLANNING PRINCIPLES AND STATE PRIORITIES

In developing the Implementation Strategy, care was taken to ensure that BH-AGH's community health priorities were aligned with priority areas determined by the Massachusetts Department of Public Health (MDPH) and the Massachusetts Attorney General's Office (MA AGO). In addition to the four priority areas, MDPH identified six health priorities to guide investments funded through Determination of Need processes. The MDPH and the MA AGO encourage hospitals to consider these priorities during the community benefits planning process.

Table 1: MA DPH/MA AGO Priority Areas

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

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

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

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

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

continuum to raise awareness about a particular condition, educate people about risk factors and protective factors, change unhealthy behaviors, and manage illness are critical to improving health status.

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

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

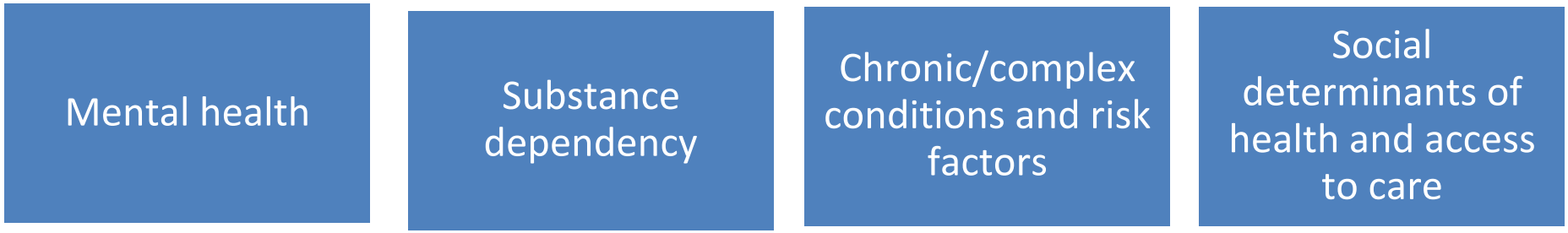
- **Care Coordination and Service Integration:** Efforts to coordinate care and integrate services across the health care continuum are critical to community health improvement. These efforts involve bringing together providers and information systems to coordinate health services, patient needs, and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

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

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

COMMUNITY HEALTH PRIORITY AREAS

BH-AGH's CHNA and strategic planning process provided many opportunities to vet the quantitative and qualitative data compiled during the assessment. The BH-AGH CBAC and Community Relations staff identified, based on this process, four community health priority areas, which together embody the leading health issues for residents of BH-AGH's service area and the barriers to care: mental health, substance dependency, chronic/complex conditions and risk factors, and social determinants of health and access to care.



Community Health Needs Not Prioritized by BH-AGH

It is important to note that there are community health needs identified by BH-AGH's assessment that were not prioritized for inclusion in the implementation strategy, for a number of reasons such as the following:

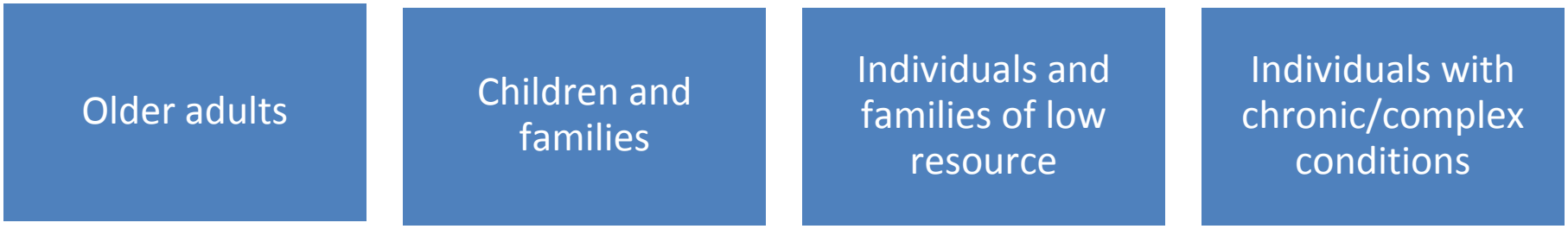
- Feasibility of BH-AGH having an impact in the short or long term
- Limited burden on residents of service area
- Existing focus on the issue by community partners, such that the issue does not warrant additional support

Namely, lack of affordable housing was identified as a community health issue, but this issue was deemed by the CBAC to be outside of BH-AGH's primary sphere of influence. This is not to say that BH-AGH will not support efforts in this area; the Hospitals remain open and willing to work with hospitals across Beth Israel Lahey Health's network and with other public and private partners to address this issue collaboratively.

The City of Lynn is a new addition to BH-AGH's service area for 2019; although the Hospitals have limited services in the area, they are open to exploring and supporting collaborative efforts to address priority health needs. While new collaborations and partnerships develop, BH-AGH will focus its efforts in other CBSA communities to ensure they have the greatest impact.

PRIORITY POPULATIONS

BH-AGH is committed to improving the health status and well-being of all residents living throughout its service area. However, in recognition of the considerable health disparities that exist in some communities, BH-AGH focuses the bulk of its community benefits resources on improving the health status of underserved populations. The CBAC voted to prioritize older adults, children and families, individuals and families of low resource, and individuals with chronic/complex conditions.



The following is BH-AGH's Implementation Strategy. The grid below provides details on BH-AGH's goals, priority populations, objectives, activities, sample measures to track progress and outcomes, and potential partners. The grid also notes, when applicable, where BH-AGH objectives align with state community health priorities. BH-AGH looks forward to working toward these goals in collaboration with community partners in the years to come.

PRIORITY AREA 1: MENTAL HEALTH

Description: As throughout the Commonwealth and the nation, the burden of mental and substance use on individuals, families, communities, and service providers in BH-AGH's community benefit service area is overwhelming. Nearly every key informant interview, focus group, and listening session included discussions on these topics. From a review of the quantitative and qualitative information, depression, anxiety/stress, and social isolation were the leading issues in this domain. There were particular concerns regarding the impact of depression and anxiety among youth and social isolation among older adults.

Despite increased community awareness and sensitivity about the underlying issues and origins of mental health issues, there is still a great deal of stigma related to these conditions. BH-AGH is committed to promoting education and prevention efforts, increasing the number of individuals who are screened and referred to appropriate services, reducing structural barriers to treatment, and maintaining the high-quality treatment services that it provides.

Resources/Financial Investment: BH-AGH will commit direct community health program investments and in-kind resources of staff time and materials. BH-AGH will also generate leveraged funds through grants from public and private sources on behalf of its own programs or services, as well as on behalf of its community partners.

<table>
<tr><th colspan="6">Goal 1: Support mental health outreach, education, and prevention programs, and improve access to treatment and services</th></tr>
<tr><th>Target Populations</th><th>Objectives</th><th>Activities</th><th>Sample Measures</th><th>Potential Partners</th><th>State Priority Area(s)</th></tr>
<tr><td rowspan="2">• Individuals and families of low resource
• Older adults
• Children and families
• Individuals with chronic/complex conditions</td><td rowspan="2">Increase the number of individuals and families educated on the risks, protective factors, and impacts of mental health issues</td><td>Support Pathways for Children Nurturing Families program in community-based settings</td><td rowspan="2">• # of individuals and/or families served
• # of sessions held (e.g., trainings, educational events, support groups)
• # of vouchers distributed
• # of referrals made
• # of meetings held
• Pre/post tests to measure changes in knowledge, motivation, ability, etc.</td><td>• Pathways for Children
• The Open Door</td><td rowspan="2">Mental illness and mental health</td></tr>
<tr><td>Provide Mental Health First Aid training(s) in community-based settings</td><td>• Local school systems
• Local health departments
• Beth Israel Lahey Health Behavioral Services</td></tr>
</table>

Goal 1: Support mental health outreach, education, and prevention programs, and improve access to treatment and services					
Target Populations	**Objectives**	**Activities**	**Sample Measures**	**Potential Partners**	**State Priority Area(s)**
• Individuals and families of low resource • Older adults • Children and families • Individuals with chronic/complex conditions	Increase the number of individuals who are screened and referred to appropriate mental health treatment and support services	Support High-Risk Intervention Team, Compass/Moms Do Care program	• # of individuals and/or families served • # of sessions held (e.g., trainings, educational events, support groups) • # of vouchers distributed • # of referrals made • # of meetings held • Pre/post tests to measure changes in knowledge, motivation, ability, etc.	Internal	Mental illness and mental health
		Support counseling and/or referral resources in community-based settings (e.g., Healing to Housing Program)		• Action Inc., • Wellspring	
	Reduce structural barriers to mental health treatment	Support BayRidge Transportation and Taxi Voucher programs		BayRidge Hospital	
	Increase access to primary care practices that have integrated behavioral health services	Enhance and promote integrated behavioral health in primary care clinics		• Primary care providers • Beth Israel Lahey Health Primary Care	
	Explore opportunities to reduce social isolation and depression	Organize and support initiatives that increase opportunities for social engagement (e.g., Widow Person Support Group, Senior Dine & Learn)		Local councils on aging	

PRIORITY AREA 2: SUBSTANCE DEPENDENCY

Description: Substance dependency has impacts on individuals, families, and communities. In nearly all key informant interviews, focus groups, and listening sessions, participants identified it as a major concern. 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 amongst adolescents. Many individuals characterized e-cigarette and vaping as an epidemic, with a need for education, prevention, and treatment services.

BH-AGH is committed to addressing the impact of substance dependency; Hospital staff and leadership will continue to be leaders and conveners in promoting collaboration and sharing knowledge with community-based partners. The Hospitals are also committed to improving access to treatment and support services through their community benefits activities.

Resources/Financial Investment: BH-AGH will commit direct community health program investments and in-kind resources of staff time and materials. BH-AGH will also generate leveraged funds through grants from public and private sources on behalf of its own programs or services, as well as on behalf of its community partners.

Goal 1: Address the impact(s) of substance dependency					
Target Populations	**Objectives**	**Activities**	**Sample Measures**	**Potential Partners**	**State Priority Area(s)**
• Individuals and families of low resource • Older adults • Children and families • Individuals with chronic/complex conditions	Promote collaboration, share knowledge, and increase awareness around the impacts and risk factors for developing substance misuse issues	Support and/or participate in task forces and community collaborations that offer education on the risks, protective factors, and impacts of substance misuse	• # of meetings attended • # of initiatives supported	• Regional/local task forces • Local public health coalitions	Substance use disorder

Goal 2: Improve access to substance misuse treatment and support services					
Target Populations	**Objectives**	**Activities**	**Sample Measures**	**Potential Partners**	**State Priority Area(s)**
• Individuals and families of low resource • Older adults • Children and families • Individuals with chronic/complex conditions	Increase the number of individuals who are screened and are referred to appropriate mental health treatment and support services	Provide recovery coaches in the emergency departments at BH-AGH; provide suboxone kits, medication-assisted treatment (SHIFT)	• # of individuals and/or families served • # of sessions held • Pre/post tests to measure changes in knowledge, motivation, ability, etc.	• Emergency Departments • Beth Israel Lahey Health Behavioral Services	Substance use disorder
		DISCOVER Partial Hospitalization Program		Internal	
		Compass/Moms Do Care Program offering counseling, group therapy, and connections to services and peer moms		Internal	

PRIORITY AREA 3: CHRONIC/COMPLEX CONDITIONS AND RISK FACTORS

Description: Heart disease, stroke, and cancer continue to be the leading causes of death in the nation and the commonwealth, and produce a significant burden on communities. Approximately six in 10 deaths can be attributed to these three conditions combined. By including respiratory disease (e.g., asthma, COPD) and diabetes, which are in the top 10 leading causes across all geographies, one can account for the vast majority of causes of death.

Many of the risk factors for these conditions are the same: physical inactivity, poor nutrition, obesity, and tobacco/alcohol use. BH-AGH has a long history of working with community partners to create awareness and education around these risk factors and their links to chronic and complex health conditions. The Hospitals will continue to support programs that provide opportunities for people to access low-cost healthy foods as well as opportunities for safe and affordable physical activity. Beyond addressing the risk factors, BH-AGH is also committed to supporting individuals and caregivers throughout the service area to engage in chronic disease management programs and to use supportive services (e.g., integrative therapies, support groups), and continues to provide linkages to care.

Resources/Financial Investment: BH-AGH will commit direct community health program investments and in-kind resources of staff time and materials. BH-AGH will also generate leveraged funds through grants from public and private sources on behalf of its own programs or services, as well as on behalf of its community partners.

Goal 1: Prevent, detect and manage chronic disease and complex conditions, and enhance access to treatment and support services					
Target Populations	**Objectives**	**Activities**	**Sample Measures**	**Potential Partners**	**State Priority Area(s)**
• Individuals and families of low resource • Older adults • Children and families • Individuals with chronic/complex conditions	Create awareness/educate community members about the preventable risk factors associated with chronic and complex health conditions	Organize and/or support programs and activities in clinical or community-based settings to provide education and prevention efforts	• # of individuals/families reached • # of education/prevention programs held • # of screenings offered • # of referrals made • # of vouchers distributed • Pre/post tests to measure changes in knowledge, motivation, ability, etc.	• American Cancer Society • Local boards of health • Local councils on aging • Local school systems	Chronic disease

Goal 1: Prevent, detect and manage chronic disease and complex conditions, and enhance access to treatment and support services					
Target Populations	**Objectives**	**Activities**	**Sample Measures**	**Potential Partners**	**State Priority Area(s)**
• Individuals and families of low resource • Older adults • Children and families • Individuals with chronic/complex conditions	Provide opportunities for people to be screened for chronic and complex health conditions, and provide linkages to associated services	Organize and/or support health screenings in clinical or non-clinical settings to detect chronic/complex conditions and refer to and/or coordinate care (e.g., skin cancer screening, blood pressure screening, breast cancer risk screening, health fairs)	• # of individuals/families reached • # of education/prevention programs held • # of screenings offered • # of referrals made • # of vouchers distributed • Pre/post tests to measure changes in knowledge, motivation, ability, etc.	• Lifestyle Management Institute • Local boards of health • Local councils on aging • Local school systems	Chronic disease
	Support individuals and their caregivers who are engaged in evidence-based support and chronic disease management programs	Organize and/or support programs and activities that refer, educate, or support individuals around better managing their chronic/complex conditions (e.g., YMCA Cornerstone Program)		• Local boards of health • Local councils on aging • North Shore YMCA	

Goal 1: Prevent, detect and manage chronic disease and complex conditions, and enhance access to treatment and support services					
Target Populations	**Objectives**	**Activities**	**Sample Measures**	**Potential Partners**	**State Priority Area(s)**
• Individuals and families of low resource •Older adults • Children and families • Individuals with chronic/ complex conditions	Increase access to affordable, healthy foods and affordable physical activity	Organize and/or support programs that provide access to free or low-cost healthy foods and physical activity (e.g., Emergency Food Bag Program, Senior Nutrition Program, Cape Ann Transportation program)	• # of individuals/families reached • # of education/prevention programs held • # of screenings offered • # of referrals made • # of vouchers distributed • Pre/post tests to measure changes in knowledge, motivation, ability, etc.	• Local councils on aging • Local food pantries • Local transportation authorities	Chronic disease
	Increase access to supportive services that reduce stress among individuals with chronic/complex conditions and their caregivers	Provide support to alleviate burden(s) associated with chronic/complex conditions to individuals and family members (e.g., Reiki, support groups, cancer navigators)		Oncology Department	

PRIORITY AREA 4: SOCIAL DETERMINANTS OF HEALTH AND ACCESS TO CARE

Description: A dominant theme from the assessment was the tremendous impact that the social determinants of health, particularly income/employment, housing, transportation, and food insecurity, have on residents within BH-AGH's CBSA. The social determinants of health are often the drivers or underlying factors that create or exacerbate mental health issues, substance misuse, and chronic/complex conditions. These social determinants of health, particularly income/employment, also underlie many of the access-to-care issues that were prioritized in the assessment, including navigating the health system (including health insurance), managing chronic disease, and affording care.

BH-AGH is committed to addressing social determinants and breaking down barriers to care. The Hospitals will continue to collaborate with community-based organizations to engage individuals in services, reduce financial burdens, increase access to appropriate primary and specialty care services, and support healthy families and communities. BH-AGH is also committed to exploring opportunities to sponsor or support mentorship, training, and employment opportunities for those in the Hospitals' service area to empower individuals to overcome financial issues and to strengthen the local workforce.

Resources/Financial Investment: BH-AGH will commit direct community health program investments and in-kind resources of staff time and materials. BH-AGH will also generate leveraged funds through grants from public and private sources on behalf of its own programs or services, as well as on behalf of its community partners.

Goal #1: Address barriers to social determinants of health and access to care					
Target Populations	**Objectives**	**Activities**	**Sample Measures**	**Potential Partners**	**State Priority Area(s)**
• Individuals and families of low resource • Older adults • Children and families • Individuals with chronic/complex conditions	Educate providers/community members about BH-AGH or public assistance programs to help them identify/enroll in appropriate health insurance plans and/or reduce their financial burden	Provide counseling, support, and referral services to community members to enroll and remain in appropriate programs (e.g., financial counseling, SHINE program)	• # of individuals/families served • # of sessions or classes offered • # of volunteers trained • # of mini grants distributed • Pre/post tests to measure changes in knowledge, motivation, ability, etc.	• Local councils on aging • NHC Financial Services	Access to health services

Goal #1: Address barriers to social determinants of health and access to care					
Target Populations	**Objectives**	**Activities**	**Sample Measures**	**Potential Partners**	**State Priority Area(s)**
• Individuals and families of low resource • Older adults • Children and families • Individuals with chronic/complex conditions	Increase access to appropriate primary care and specialty care services	Support programs that provide clinical services in community-based settings (e.g., Health Center at Gloucester High School, Mobile Phlebotomy)	• # of individuals/families served • # of sessions or classes offered • # of volunteers trained • # of mini grants distributed • Pre/post tests to measure changes in knowledge, motivation, ability, etc.	• Gloucester High School	• Access to health services
	Increase access to affordable and nutritious foods	Provide mini grants to community partners that address issues associated with food insecurity		• Local food pantries • Other organizations addressing food insecurity	• Food access • Chronic disease
	Increase mentorship, training, and employment opportunities	Explore employment and workforce development issues, including existing community resources and programs		To be determined	• Employment • Built environment
		Identify opportunities to strengthen the workforce, including education and job training		To be determined	• Employment

• Individuals and families of low resource • Older adults • Children and families • Individuals with chronic/complex conditions	Increase awareness about creating a healthy, safe environment for babies and families, and promote healthy child development	Organize and/or support programs that promote a healthy, safe environment and/or that foster healthy growth and development for infants and babies and their families (Compass/Moms Do Care Program, Connecting Young Moms, Cuddler Program, BH Parent Education, Lactation Boutique, etc.)	• # of individuals/families served • # of sessions or classes offered • # of volunteers trained • # of mini grants distributed • Pre/post tests to measure changes in knowledge, motivation, ability, etc.	• Local boards of health • BH Parent Education • BH Maternal Health	Social environment
	Increase access to affordable and free opportunities for physical activity	Support community-based initiatives to offer free or low-cost physical activity (Osteo Class, Enhance Fitness)		• North Shore YMCA • Senior centers/councils on aging	• Access • Built environment
	Ensure access to preventive measures, testing, screening and treatment for those at-risk or exposed to COVID-19 and mitigate the impacts of the pandemic on the social determinants of health	Support community and hospital-based activities that address the impacts of COVID 19 in the community		To be determined	